

**UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF ALABAMA**

ROY LASSITER, JENNIFER  
PURIFOY,

Plaintiffs,

**V.**

PACIFICARE LIFE AND HEALTH  
INSURANCE COMPANY, UNITED  
HEALTHCARE SERVICES, INC., as  
successor in interest to PacifiCare  
Life & Health Company; ROBERT D.  
BELL and Fictitious Defendants "A"  
through "R",

Defendants.

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CIVIL ACTION NO. 2:07-CV-00583

**DEFENDANTS PACIFICARE LIFE AND HEALTH INSURANCE COMPANY  
AND UNITED HEALTHCARE SERVICES, INC.'S  
MOTION TO STAY OR ABATE PROCEEDINGS AND COMPEL ARBITRATION**

COME NOW Defendants PacifiCare Life and Health Insurance Company and United HealthCare Services, Inc., (together, “PacifiCare”), through counsel, and file their Motion to Stay or Abate Proceedings and Compel Arbitration (the “Motion”), as follows:

PacifiCare moves to stay or abate proceedings and compel arbitration based upon the existence of an agreement to arbitrate between Plaintiffs and PacifiCare.

## **I. Evidence Supporting Motion**

This Motion relies on the Affidavit of Linda Whetson, filed separately as an Appendix to this Motion, including the following exhibits attached thereto and incorporated herein by reference:

- (1) “SecureHorizons Direct Individual Election Form” agreement signed by Plaintiff Roy Lassiter (“Lassiter”) (Exh. 1 thereto), which contains binding arbitration provisions (the “Enrollment Agreement”);<sup>1</sup>
- (2) “Evidence of Coverage” agreement (Exh. 2 thereto); and
- (3) “Summary of Benefits” agreement (Exh. 3 thereto).

## **II. Factual Background**

Plaintiffs filed suit against PacifiCare and the insurance broker co-defendant, Robert D. Bell (“Bell”), for their alleged actions to contact Plaintiffs, misrepresent PacifiCare’s Secure Horizons Direct “Private Fee For Service” Medicare product (“PFFS Plan”), dis-enroll Plaintiffs from their existing Medicare coverage, redirect Medicare premiums to PacifiCare, and restrict Plaintiffs’ Medicare coverage and benefits. Plaintiffs assert causes of action for intentional, negligent or reckless misrepresentation (fraud); suppression; negligent, reckless or wanton hiring, training, monitoring and supervision; conspiracy to defraud; unjust enrichment/constructive trust; negligence and wantonness; breach of fiduciary duties; intentional, wanton, reckless and/or negligent infliction of emotional distress; and violation of the Alabama Deceptive Trade Practices Act. (See Plaintiffs’ Complaint, pp. 6-14). In addition to compensatory and punitive damages, Plaintiffs seek to impose a constructive trust on payments and related fees paid by Plaintiffs to PacifiCare. (*Id.* at ¶ 40).

All of Plaintiffs’ claims are based upon or derived from the existence of an Enrollment Agreement by which the Plaintiffs were enrolled in PacifiCare’s PFFS Plan.

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<sup>1</sup> PacifiCare has no record of Plaintiff Jennifer Purifoy (“Purifoy”) executing an Enrollment Agreement for coverage. To the extent Plaintiff Purifoy alleges execution of an Enrollment Agreement on or around May 23, 2006, however, such agreement would contain identical arbitration language as the Enrollment Agreement for Plaintiff Lassiter attached to the Appendix as Exhibit 1. (See App. at ¶ 3, Exh. 1).

The Enrollment Agreement for Plaintiff Lassiter, reflecting his signature and dated May 23, 2006<sup>2</sup>, verifies his proper enrollment in PacifiCare's PFFS Plan. (App. at Exh. 1). Plaintiff Jennifer Purifoy ("Purifoy") also alleges that she enrolled in PacifiCare's PFFS Plan on or around May 23, 2006. (See Plaintiffs' Complaint at ¶¶ 11, 15).<sup>3</sup> PacifiCare has no record of any Enrollment Agreement executed or submitted by Purifoy. To the extent that Purifoy affirmatively alleges enrollment in PacifiCare's PFFS Plan on or around the same date as Lassiter, however, Purifoy's Enrollment Agreement would contain identical language as Lassiter's Enrollment Agreement. (App. at ¶ 3). Therefore, both Lassiter and Purifoy are subject to the terms of the Enrollment Agreement attached to the Appendix as Exhibit 1. (See App. at Exh. 1).

The Enrollment Agreement contains a binding arbitration provision, in bolded and capitalized text, as follows:

**....I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PLHIC [Defendant PacifiCare Life and Health Insurance Company] OR ANY OF ITS PARENTS [Defendant PacifiCare Health Plan Administrators, Inc.] SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT**

<sup>2</sup> While Lassiter's Enrollment Agreement is dated May 23, 2005, the imaging stamp and processing date (May 30, 2006) located at the top the Agreement indicate that such date of execution actually should reflect May 23, 2006—not 2005. See App. at Exh. 1.

<sup>3</sup> While Plaintiffs' Complaint alleges enrollment in the PFFS Plan on May 23, 2005, such date should reflect May 23, 2006, based on the imaging stamp and processing date located at the top of the Enrollment Agreement. See App. at Exh. 1.

**PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.**

(See App. at Exh. 1, p. 2 (above “Signature of applicant”)).

When a customer, such as either Plaintiff, enrolls under the PFFS Plan and their enrollment is confirmed by the Centers for Medicare and Medicaid Services (“CMS”), PacifiCare provides the enrollee with an Evidence of Coverage (“EOC”) and a Summary of Benefits (“Summary”). (See App. at ¶ 4, Exh. 2-3). The EOC provides:

**Binding Arbitration**

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between Enrollee (including any heirs or assigns) and PLHIC or any of its parents, subsidiaries or affiliates (collectively, “PacifiCare”), shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Enrollee and PacifiCare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing.

(App. at Exh. 2, pp. 39-40). The EOC also sets forth specific procedures for arbitration of claims, including the appointment of arbitrators, locale of the arbitration, discovery procedures, and authorized awards. (See *Id.*).

The EOC and the Summary, together with the Enrollment Agreement, comprise the entire agreement between the customer and PacifiCare with respect to the customer’s PFFS Plan (collectively, the “PacifiCare Agreements”). (See App. at ¶ 4).

All of Plaintiffs' claims herein center around the validity of the PacifiCare Agreements, regardless of whether they sound in tort or contract, or arise under common law or statute. Accordingly, Plaintiffs' claims are subject to the terms and conditions of the PacifiCare Agreements.

### **III Argument and Authorities**

Because Plaintiffs' exclusive remedy for resolving any dispute arising out of the PacifiCare Agreements is binding arbitration, this Court should compel arbitration as set forth in each agreement and stay all proceedings in this case pending arbitration.

Federal law favors arbitration, requiring all reasonable presumptions in favor of arbitration. See *Howsam v. Dean Witter Reynolds, Inc.*, 537 U.S. 79, 83 (2002); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Co.*, 460 U.S. 1 (1983); *Steel Warehouse Co. v. Abalone Shipping Ltd. of Nicosai*, 141 F.3d 234 (5th Cir. 1998). Courts must "rigorously enforce agreements to arbitrate," *Dean Witter Reynolds, Inc. v. Byrd*, 470 U.S. 213, 221 (1985), and any doubts regarding the scope of an arbitration agreement should be resolved in favor of arbitration. *Dockser v. Schwartzberg*, 433 F.3d 421, 425 (4<sup>th</sup> Cir. 2006); *Safer v. Nelson Fin. Group*, 422 F.3d 289, 294 (5<sup>th</sup> Cir. 2005); *Alticor, Inc. v. National Un. Fire Ins. Co.*, 411 F.3d 669, 672-73 (6<sup>th</sup> Cir. 2005); see *InterGen N.V. v. Grina*, 344 F.3d 134, 142 (1<sup>st</sup> Cir. 2003) (Court has "unflagging, nondiscretionary duty" to grant motion to compel arbitration if the parties are bound to arbitrate and the district court has jurisdiction). The federal policy favoring arbitration imposes a heavy burden on those seeking to avoid arbitration. *Sibley v. Tandy Corp.*, 543 F.2d 540, 542 (5th Cir. 1976).

The dispute in this matter is properly the subject of arbitration. The PacifiCare Agreements provide the exclusive procedure for the resolution of disputes, which is binding arbitration. This agreement falls within the scope of the Federal Arbitration Act (the "FAA"), which reflects the strong federal policy in favor of arbitration. See 9 U.S.C. § 2. The FAA provides the statutory expression of a "liberal federal policy favoring arbitration agreements." *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91 (2000); *Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983); see also *Neal v. Hardee's Food Systems, Inc.* 918 F.2d 34, 37 (5th Cir. 1990) ("In addressing questions of arbitrability, we must, however, keep in mind the strong federal policy favoring arbitration, [and we] resolve doubts concerning the scope of coverage of an arbitration clause in a contract in favor of arbitration.").

Accordingly, this Court should compel arbitration and stay or abate this case pending the completion of arbitration.

#### IV. Prayer

WHEREFORE, Defendants PacifiCare Life and Health Insurance Company and United HealthCare Services, Inc., pray that this Court compel arbitration and stay or abate all further proceedings, and for any further relief to which said Defendants may be justly entitled.

DATED: June 29, 2007.

Respectfully submitted,

s/ Philip H. Butler  
 Philip H. Butler (BUT007)  
 George B. Harris (HAR138)  
 William C. McGowin (MCG040)

OF COUNSEL

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Fax: 713-752-4221

ATTORNEYS FOR DEFENDANTS  
PACIFICARE LIFE AND HEALTH  
INSURANCE COMPANY and UNITED  
HEALTHCARE SERVICES, INC.

**CERTIFICATE OF CONFERENCE**

On June 29, 2007, the undersigned counsel for Movants conferred with Plaintiffs' counsel to determine if Plaintiffs would agree to arbitration of this matter, and Plaintiffs' counsel stated that his clients would not agree to arbitration, thus requiring the filing of this motion.

s/ Philip H. Butler  
\_\_\_\_\_  
Of Counsel

**CERTIFICATE OF SERVICE**

I hereby certify that on June 29, 2007, I electronically filed the foregoing Motion to Stay or Abate Proceedings and Compel Arbitration with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

Robert G. Methvin, Jr.  
J. Matthew Stephens  
Rodney E. Miller  
*McCallum, Methvin & Terrell, P.C.*  
The Highland Building  
2201 Arlington Avenue South

*Attorney for Plaintiffs*

and I hereby certify that I have mailed by United States Postal Service the document to the following non-CM/ECF participants:

Robert D. Bell  
Route 1, Box 995  
Shellman, Georgia, 39886

Respectfully submitted,

s/ Philip H. Butler  
\_\_\_\_\_  
Of Counsel

**AFFIDAVIT OF LINDA WHETSON**

THE STATE OF COLORADO     §  
                                              §  
COUNTY OF DENVER         §

Before me, the undersigned authority, personally appeared Linda Whetson, who, being by me duly sworn, deposed as follows:

1.       “My name is Linda Whetson; I am over 21 years of age; I am fully competent to make this Affidavit; and I have never been convicted of a felony. All of the facts contained herein are true and correct to the best of my knowledge and belief.

2.       In my capacity as a Director of Business Risk Management, I provide services to PacifiCare Life and Health Insurance Company d/b/a Secure Horizons (“PacifiCare”). I am authorized to make this Affidavit on behalf of PacifiCare. I have reviewed, and am familiar with, the records of PacifiCare with respect to the matters sworn to below.

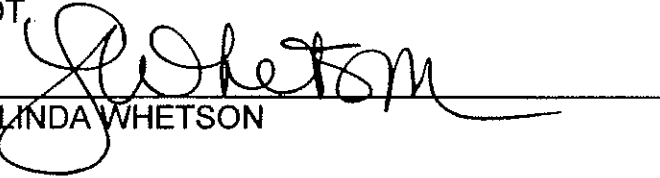
3.       PacifiCare maintains in its business records a SecureHorizons Direct Individual Election Form (“Enrollment Agreement”) for Plaintiff Roy Lassiter (“Lassiter”). A true and correct copy of Lassiter’s Enrollment Agreement is attached hereto as Exhibit 1. While Lassiter’s Enrollment Agreement indicates that it was executed on May 23, 2005, the imaging stamp and processing date located at the top the Agreement reflect enrollment in May, 2006. PacifiCare has no record of an executed or submitted Enrollment Agreement for Plaintiff Jennifer Purifoy (“Purifoy”). To the extent Plaintiff Purifoy alleges executing an Enrollment Agreement on or about May 23, 2006, however, such agreement would contain the same arbitration language as the Enrollment Agreement for Plaintiff Lassiter attached hereto as Exhibit 1.

4.       When a customer, such as either Plaintiff, enrolls under the Secure Horizons Private Fee For Service (“PFFS”) plan and their enrollment is confirmed by the Centers for Medicare and Medicaid Services (“CMS”), PacifiCare provides the enrollees with an Evidence of Coverage (“EOC”) and a Summary of Benefits (“Summary”). True and correct copies of the EOC and Summary are attached hereto as Exhibits 2 and 3. The EOC and the Summary, together with the Enrollment Agreement, comprise the entire agreement between the customer and PacifiCare with respect to the customer’s PFFS Plan.

5.       I am a custodian of records for PacifiCare, including the documents attached hereto as Exhibits 1-3. The Enrollment Agreement, EOC and Summary are kept by PacifiCare in the regular course of its business, and it was in the regular course of its business for an employee or representative of PacifiCare to maintain the records; and the records were maintained at or near the time they were received by PacifiCare or

reasonably soon thereafter. The records attached hereto are the exact duplicates of the originals which were provided to PacifiCare."

FURTHER AFFIANT SAYETH NOT.

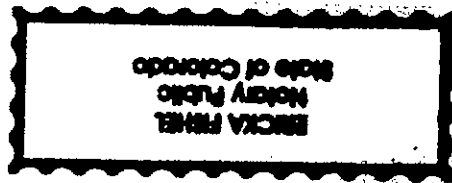
  
LINDA WHETSON

SUBSCRIBED and SWORN TO before me on this the 27 day of June, 2007 to certify my hand and official seal.

  
Notary Public, State of Colorado

My commission expires:

Nov 20, 2007



# **Exhibit 1**

**SecureHorizons Direct<sup>SM</sup>**  
*from PacificCare<sup>SM</sup>*  
 A Private Fee for Service Health Plan

**IMAGING**  
 MAY 30 2006

**SecureHorizons Direct<sup>SM</sup>**  
**Individual Election Form**

1381263

187323

Rec'd 5/30/2006

Please fill in all information requested. Please read the back of this form.

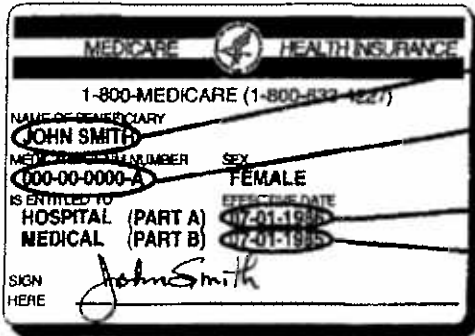
If available, I prefer to receive materials in the following language: ☒ English ☐ Spanish

Choose one benefit plan. Please refer to your Summary of Benefits for detailed information on SecureHorizons Direct<sup>SM</sup> service area, benefits, services and costs associated with the plans.

☐ Plan 1 ☒ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 ☐ Premier 100 ☐ Premier 200

|                                                                                                         |                 |                                              |                       |                                                                          |
|---------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------|-----------------------|--------------------------------------------------------------------------|
| Last name <u>Lassiter</u>                                                                               |                 | First name <u>Roy</u>                        |                       | Middle initial <u>A</u>                                                  |
| Permanent residential address (must be where you permanently reside - not P.O. Box)<br><u>737 CR 30</u> |                 |                                              |                       |                                                                          |
| City <u>Union Springs</u>                                                                               | State <u>AL</u> | Zip <u>36089</u>                             | County <u>Bullard</u> |                                                                          |
| Telephone number <u>334-738-3649</u>                                                                    |                 | Birth date (Month/Day/Year) <u>7-28-1941</u> |                       | <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security Number (providing this information is optional)                                         |                 |                                              |                       |                                                                          |
| Mailing address (if different than above)                                                               |                 |                                              |                       |                                                                          |
| Second telephone number (if applicable)                                                                 |                 |                                              | E-mail address        |                                                                          |
| In Care of mailing (if different than above) Last name                                                  |                 |                                              | First name            |                                                                          |
| Mailing address                                                                                         |                 | City                                         | State                 | Zip                                                                      |
| Doctor name <u>Rosalina Aguilar MD</u>                                                                  |                 | Doctor telephone number <u>334-738-2146</u>  |                       |                                                                          |

Please fill in the blanks below with the information on your Medicare card. If possible, also attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.



Roy A. Lassiter  
 Beneficiary's Name  
237-60-8487-A  
 Medicare Claim Number Letter  
 Is entitled to:  
 Part A (Hospital) effective date 3-1-1995  
 Part B (Medical) effective date 3-1-1995

Please choose one billing method option:

- ☐ Billing  
☐ EasyPay (automatic deduction from your bank account)  
☐ Credit Card (automatic deduction from your credit card account)

Please choose one billing cycle:

- ☐ Monthly ☒ Quarterly  
☐ Semi-annual ☐ Annual

**Plan Copy**

1381263

|                                                                                                                                                                                                                                                           |  |                                       |                         |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------|-------------------------|-----|
| Do you have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                    |  |                                       |                         |     |
| If you have ESRD, you cannot enroll in the SecureHorizons Direct <sup>SM</sup> Plan unless you are currently enrolled in a PacifiCare Commercial Plan or you were affected by the non-renewal of another Medicare Advantage Plan after December 31, 1998. |  |                                       |                         |     |
| If you have had a successful kidney transplant and no longer need regular dialysis you may be asked to provide documents from your doctor stating this.                                                                                                   |  |                                       | If Yes, Member Number   |     |
| If Yes, are you currently a member of a PacifiCare Commercial Plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                   |  |                                       |                         |     |
| <b>Your answers to the questions below will not affect your eligibility to enroll in SecureHorizons Direct<sup>SM</sup>:</b>                                                                                                                              |  |                                       |                         |     |
| Do you or your spouse have any other health insurance other than Medicare such as private insurance, Workers' Compensation, or VA benefits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |  |                                       | If Yes, Name of Carrier |     |
| Are you currently a Medicaid recipient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Medicaid Number                                                                                                                       |  |                                       |                         |     |
| Are you currently a resident in an Institution (e.g., skilled nursing facility, rehabilitation hospital, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                       |  |                                       |                         |     |
| If Yes, Name of Institution                                                                                                                                                                                                                               |  |                                       |                         |     |
| Address of Institution (number and street)                                                                                                                                                                                                                |  | City                                  | State                   | Zip |
| Telephone number of Institution                                                                                                                                                                                                                           |  | Your Date of Admission in Institution |                         |     |

My signature below warrants that I have read and understand this Individual Election Form, including the Statement of Understanding on the back of this form, and that the information provided by me is accurate and complete. I understand that as an enrollee of SecureHorizons Direct<sup>SM</sup> I have the right to appeal service and payment denials made by PacifiCare Life and Health Insurance Company (PLHIC). I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PLHIC, OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

You must sign and date this Individual Election Form in order for it to be processed.

|                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                  |                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| SECURE HORIZONS USE ONLY<br><input type="checkbox"/> I <input type="checkbox"/> A <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> Y<br>SECURE HORIZONS EFFECTIVE DATE<br>COVERAGE PLAN CODE<br>DATA ENTRY INITIALS      DATE<br>REP. ID # |  | Signature of applicant<br>Signature of individual who assisted in completing this form<br>Relationship to applicant<br><input type="checkbox"/> If Durable Power of Attorney, indicate here and attach certificate or other written proof of legal guardianship. | Date<br>Date<br>Date |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|

Agent's/Broker's Signature: KD Bell      Date: 5-23-05  
 Agent's/Broker's Full Name (please print): Robert D Bell      Agent/Broker Number: 072252

FMO Name

Plan Copy

**MEDICARE COMPLETE ENROLLMENT APPLICATION CHANGE FORM**

*Instructions: Only fill in information that has changed or is different than information on the original application.  
No changes should be made directly to the application.*

**SECTION I.**

|                          |                      |
|--------------------------|----------------------|
| Name:                    | Group Number:        |
| Effective Date:          | Alternate ID Number: |
| Mailing Address:         | Home Address:        |
| Telephone Number:        | Date of Birth:       |
| Social Security Number:  | Medicare Number:     |
| Name of Employer Group : |                      |

Other Changes:

05/31/200609:37

Form Completed by:

Date:

*Proprietary and Confidential*

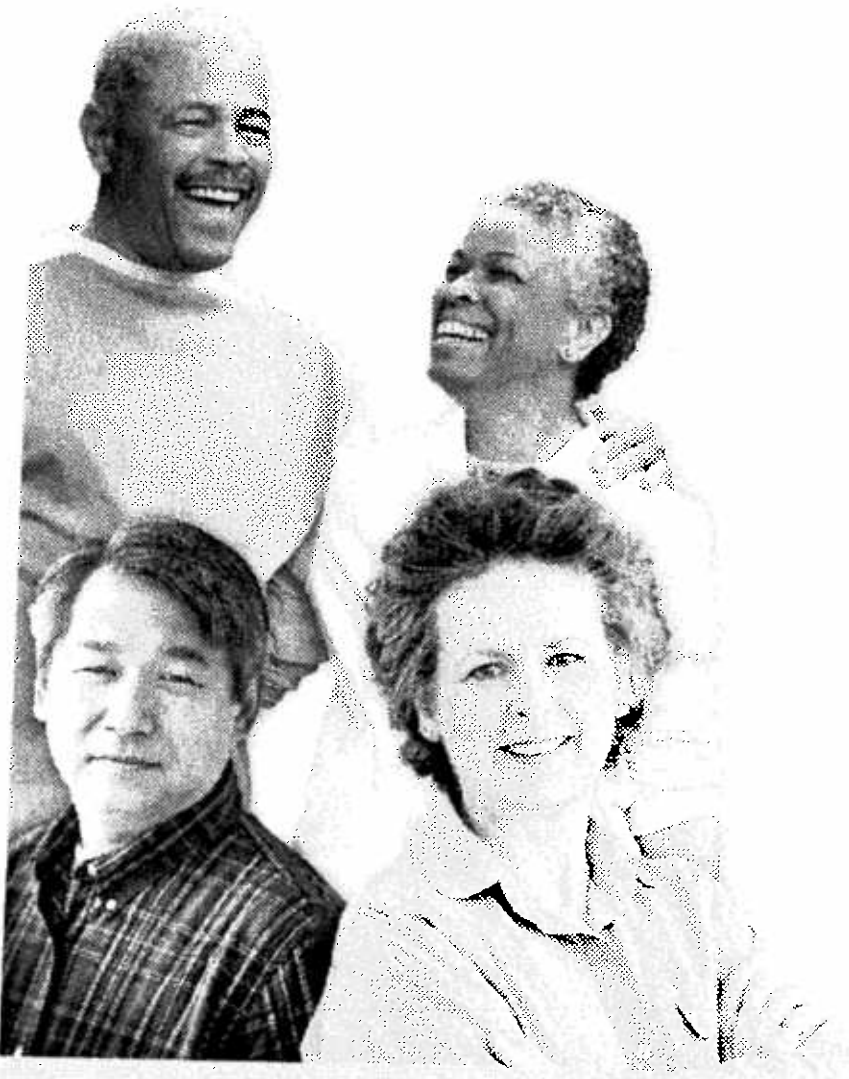
**PLEASE INCLUDE THE CORRECT GROUP NUMBER FOR THE CHANGE REQUESTED.**

# **Exhibit 2**

SecureHorizons Direct<sup>SM</sup>  
from **PacifiCare**<sup>SM</sup>  
A Private Fee for Service Health Plan

# EVIDENCE OF COVERAGE

SecureHorizons Direct<sup>SM</sup>



Effective January 1, 2006  
through December 31, 2006

H5435



---

## Reference Page

Please fill this out for your reference:

---

Your SecureHorizons Direct<sup>SM</sup> enrollment  
identification number (located on your  
SecureHorizons Direct<sup>SM</sup> ID card)

---

Your Effective Date of Enrollment

### Questions? Problems? Need help?

Call Customer Service at 1-866-272-0407  
(TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST,  
Monday through Friday.

Write:

P.O. Box 4169  
Scranton, PA 18505

Visit the Web site at  
[www.securehorizons.com](http://www.securehorizons.com)

**This Evidence of Coverage contains the  
terms and conditions of coverage and rights  
you have with SecureHorizons Direct<sup>SM</sup>  
offered by PacifiCare Life and Health  
Insurance Company (PLHIC). All applicants  
have a right to view this Evidence of  
Coverage and the Schedule of Benefits prior  
to enrollment. This information should be  
read completely and carefully. Individuals  
with special needs should carefully read  
those sections that apply to them.**

This document will be mailed to you annually.  
This document is effective January 1 through  
December 31, 2006.

Federal law mandates that PLHIC comply with  
Title VI of the Civil Rights Act of 1964, the  
Rehabilitation Act of 1973, the Age Discrimination  
Act of 1975, the Americans with Disabilities Act,  
and other laws applicable to recipients of federal  
funds, and all other applicable laws and rules.  
Specifically, PLHIC does not discriminate either  
in the employment of staff or in the provision  
of health care services on the basis of race,  
disability, religion, sex, sexual orientation, health,  
ethnicity, creed, age or national origin.

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## Welcome to SecureHorizons Direct<sup>SM</sup>!

PacificCare Life and Health Insurance Company (PLHIC) is pleased that you've chosen SecureHorizons Direct<sup>SM</sup> a Medicare Advantage Private Fee-For-Service Plan for people with Medicare. SecureHorizons Direct<sup>SM</sup> is offered by PLHIC, a Medicare Advantage Private Fee-For-Service Organization. Your contract for SecureHorizons Direct<sup>SM</sup> consists of this Evidence of Coverage, the Schedule of Benefits, your Individual Election Form and any current or future amendments.

This Evidence of Coverage and the Schedule of Benefits explain your rights, benefits, responsibilities, and further describe how to get your coverage under Medicare as an Enrollee of SecureHorizons Direct<sup>SM</sup>. They also explain PLHIC's responsibilities to you. These documents will be mailed to you annually. Please read them carefully and keep them in a safe place, available for quick reference. If you have special needs, this document may be available in other formats.

SecureHorizons Direct<sup>SM</sup> is not an insurance policy that merely pays Medicare deductibles and Coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, PLHIC has entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the federal governmental agency that administers Medicare and is also regulated by the Department of Insurance in your State. The contract with CMS authorizes PLHIC to provide comprehensive health services for individuals who are entitled to Medicare benefits and who choose to enroll in SecureHorizons Direct<sup>SM</sup>. When you join SecureHorizons Direct<sup>SM</sup> you may pay a monthly Health Plan Premium, as well as Copayments and Coinsurance amounts, up to an annual Out-of-Pocket Maximum.

SecureHorizons Direct<sup>SM</sup> covers all services and supplies offered by Medicare, plus certain additional services and supplies not covered by Medicare. PLHIC has signed a contract with CMS agreeing to cover you for the Calendar Year. SecureHorizons Direct<sup>SM</sup> costs and benefits may

change from year to year and PLHIC will notify you before any changes are made. In addition, either CMS or PLHIC may choose not to renew all or a portion of the contract. If the contract is not renewed, your Medicare coverage will be switched to Original Medicare unless you decide to switch to another Medicare Advantage plan. If either CMS or PLHIC decides not to renew the contract at the end of the year, you will receive a letter at least ninety (90) days before the end of the contract. If CMS ends the contract in the middle of the year, you will receive a letter at least thirty (30) days before the end of the contract. In either situation the letter would explain your options for health care coverage in your area and provide information about your right to obtain Medicare supplemental insurance coverage.

By enrolling in SecureHorizons Direct<sup>SM</sup> you have agreed to follow all plan rules, such as ensuring that you utilize Deemed Providers for your health care. For more information on Deemed Providers, refer to Section 4.

### Call Customer Service Whenever You Need Information

In addition to providing coverage for Covered Services, PLHIC strives to provide the information you need about SecureHorizons Direct<sup>SM</sup> when you need it.

PLHIC has specially trained Customer Service Representatives who can answer your questions about:

- Covered Services
- Making address or telephone number changes
- Enrollment or Disenrollment
- Appeal and Grievance complaint rights
- Questions about Claims
- Any other questions or concerns regarding SecureHorizons Direct<sup>SM</sup>

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

### **Updating Your Enrollment Records**

Your SecureHorizons Direct<sup>SM</sup> enrollment record contains information from your Individual Election Form including your address and telephone number, as well as your specific benefit plan coverage. These records are very important because they identify you as an eligible SecureHorizons Direct<sup>SM</sup> Enrollee and determine if you are eligible to receive Covered Services.

Please report any changes in name, address or phone number to Customer Service immediately.

You should also report any changes in health insurance coverage you have from your employer or your spouse's employer. Additionally, you should report any liability health care claims (such as claims against another driver in an auto accident), eligibility under Workers' Compensation and Medicaid/Medi-Cal.

### **If You Move From One Service Area to Another Service Area or Join a Premier Plan**

If you move from one Service Area to another Service Area, you can still remain an Enrollee of SecureHorizons Direct<sup>SM</sup>. (To locate our current Service Areas, please see Section 13.) After you move, call Customer Service. Generally, requests received by the end of the month will be effective the first day of the following month. For example, if your request is received on January 20, the Effective Date of your new benefit plan will be February 1.

Benefit plans in different Service Areas may offer different benefits, Health Plan Premiums, Copayment and Coinsurance amounts. Call Customer Service and ask for the Summary of Benefits for the Service Area that you are moving to so that you may review and understand any differences.

If available in your Service Area, you can choose to join one of our new Premier Plans. Call Customer Service to request a Summary of Benefits and instructions regarding transferring. Transfers into Premier Plans are only allowed at certain times during the year. Please ask Customer Service for more information.

Until your Effective Date, you will remain with your previously selected benefit plan. You will continue to receive the benefits that are a part of that benefit plan, as long as you have made any applicable Health Plan Premium payments.

### **PLHIC is Interested in Your Comments**

PLHIC's goal is to provide the Covered Services you need to stay as healthy and active as you can. PLHIC is interested in your comments. From time to time, PLHIC will be asking for your thoughts on SecureHorizons Direct<sup>SM</sup> through voluntary satisfaction surveys. These surveys help PLHIC measure our ability to assist you with your health care coverage concerns.

### **How to Submit a Claim**

All Covered Services should be billed by the Deemed Provider directly to PLHIC. However, if you receive a bill for a Covered Service or Emergency Service, please send the Claim for payment determination to:

SecureHorizons Direct<sup>SM</sup> Claims Department  
P.O. Box 4169  
Scranton, PA 18505

You are responsible for paying Copayments and Coinsurance, if any, for Covered Services directly to the Provider up to your annual Out-of-Pocket Maximum. Expenses not covered by SecureHorizons Direct<sup>SM</sup> do NOT count toward your annual Out-of-Pocket Maximum. If you have any questions about any Claims, please call Customer Service. Please refer to the Schedule of Benefits to find out the amount of your Out-of-Pocket Maximum.

## Section 1

### Health Care Terms

The following definitions apply to this Evidence of Coverage.

**Accepts Medicare Assignment** – Physicians, physical therapists, occupational therapists and Durable Medical Equipment suppliers that participate in Medicare and accept Medicare Allowable Charges as payment in full for services provided to Medicare beneficiaries.

**Acute Care** – Treatment for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute Care is usually received in a Hospital from specialized personnel using complex and sophisticated technical equipment and materials. This pattern of care is often necessary for a short time, unlike chronic care, where no significant improvement can be expected.

**Advance Coverage Decision** – A decision made by a Medicare Advantage Private Fee-For-Service Organization as to whether a requested health care service is a Medically Necessary Covered Service.

**Appeal** – The type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service or what PLHIC will pay for a service. You can file an Appeal in the following examples:

- If PLHIC refuses to cover or pay for services you think PLHIC should cover
- If PLHIC or a Provider refuses to give you a service you think should be covered
- If PLHIC or a Provider reduces or cuts back on services you have been receiving
- If you think that PLHIC is stopping your coverage too soon

**Balance Billing** – Physicians, occupational therapists or Durable Medical Equipment suppliers that do not Accept Medicare Assignment and choose to bill the Medicare beneficiary for the balance of their private fees that exceed the Medicare Allowed Charges, not to exceed the

Medicare Limiting Charge of 115% of Medicare Allowable Charges.

**Benefit Period** – A Benefit Period is a way of measuring your use of services under Medicare Part A. A Benefit Period begins with the first day you go to a Medicare-covered inpatient Hospital or a Skilled Nursing Facility and ends when you have not received any Hospital or Skilled Nursing Facility care for sixty (60) days in a row. If you go to the Hospital (or Skilled Nursing Facility) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. **Original Medicare Hospital Benefit Periods do not apply for Inpatient Hospital stays through SecureHorizons Direct.<sup>SM</sup>**

**Calendar Year** – A twelve- (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal Agency responsible for administering Medicare.

**Claim** – Notification in a form acceptable to PLHIC that a Covered Service has been rendered or furnished to an Enrollee. This notification must set forth in full the details of such Covered Service as required by PLHIC.

**Coinsurance** – A percentage of the cost of a Covered Service an Enrollee is required to pay either at the time of service or when billed by the Provider. An Enrollee's Coinsurance amount is based on Medicare Allowable Charges (MAC) or, for services not included in MAC, Coinsurance is based upon PacifiCare Life and Health Insurance Company's Medicare Proxy Payment.

**Copayment** – That portion of the Covered Service that is the responsibility of the Enrollee and is shown on the Schedule of Benefits and Summary of Benefits.

**Covered Services** – Medically Necessary services or supplies provided under the terms of the Evidence of Coverage and the Schedule of Benefits.

**Custodial Care** – Not a Covered Service. Custodial Care includes services that assist

an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of the administration of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

**Customer Service** – A department dedicated to answering your questions concerning (but not limited to) your enrollment, Covered Services, Grievances and Appeals rights.

**Deemed Provider** – Physicians, Providers, physical therapists, occupational therapists and Durable Medical Equipment suppliers that participate in Medicare are deemed to have a contract with a Medicare Advantage Private Fee-For-Service Organization when the following conditions are met:

1. In advance of furnishing Covered Services, the Provider knows that a patient is enrolled in SecureHorizons Direct<sup>SM</sup>
2. The Provider either possesses or has access to PacifiCare Life and Health Insurance Company's (PLHIC's) Terms and Conditions of payment and participation (which is available by calling the 800 number for Providers or accessing the Web site found on the back of your ID card).
3. The Provider agrees to submit the bill for Covered Services directly to PLHIC for payment.

A Provider has the right to decide whether or not he/she will agree to be a Deemed Provider each time he/she furnishes Covered Services to you. If the Provider bills you directly for Covered Services, forward the Claim to PLHIC for payment to your Provider for Covered Services, minus your cost-sharing amount (i.e., the applicable Copayment or Coinsurance amount).

**Disenroll or Disenrollment** – The process of ending your enrollment in SecureHorizons Direct<sup>SM</sup>. Disenrollment can be voluntary or involuntary.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

### **Durable Medical Equipment (DME) –**

Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Provider for use in your home, such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines. The decision to rent or purchase a DME item is determined by your Provider or PLHIC.

**Effective Date** – The date your SecureHorizons Direct<sup>SM</sup> coverage begins. You receive written notification of your Effective Date from PLHIC.

**Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the Enrollee's health in serious jeopardy; 2) serious impairment to bodily functions; 3) serious dysfunction of any bodily organ or part. In the case of a pregnant woman, an Emergency Medical Condition exists if the Enrollee is in active labor, meaning labor at a time at which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or b) a transfer may pose a threat to the health and safety of the Enrollee or the unborn child.

**Emergency Services** – Covered Services that are 1) furnished by a Provider qualified to furnish Emergency Services, and 2) needed to evaluate or stabilize a medical emergency. Please see definition of Emergency Medical Condition.

**Enrollee (Member)** – A Medicare beneficiary who has voluntarily enrolled in SecureHorizons Direct<sup>SM</sup> and whose enrollment has been confirmed by CMS and who is entitled to receive Covered Services.

**Evidence of Coverage** – This document explains Covered Services and defines your rights and responsibilities as an Enrollee and those of PLHIC.

**Exclusion or Excluded** – Items or services which are not covered under this Evidence of Coverage, which includes the Schedule of Benefits. Exclusions are disclosed in the Schedule of Benefits. You are responsible for paying for excluded items or services.

**Experimental Procedures and Items** – Items and procedures determined by PLHIC and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, PLHIC will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable, or rely upon determinations already made by Medicare. Experimental Procedures and Items are not covered under this Evidence of Coverage.

**Grievance** – The type of complaint you make if you have a complaint or problem that does not involve payment or services by PLHIC or a Provider. For example, you would file a Grievance if you have a problem with things such as the quality of your care, general dissatisfaction with the way SecureHorizons Direct<sup>SM</sup> benefits are designed, waiting times for appointments or in the waiting room, the way your doctors or others behave, not being able to reach someone by phone or obtain the information you need, or the lack of cleanliness or condition of the doctor's office.

**Health Plan Premium** – The monthly payment to PLHIC, if applicable, along with the Medicare Part B Premium and Medicare Part A Premium, paid to Medicare if applicable, that entitle you to the Covered Services outlined in this Evidence of Coverage.

**Home Health Agency** – A Medicare-certified agency, which provides intermittent Skilled Nursing Care and other Medically Necessary therapeutic services in your home when you are confined to your home.

**Hospice** – An organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

**Hospital** – A Medicare-certified institution licensed by the State, which provides inpatient,

outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

**Independent Review Entity** – An entity under contract with CMS, such as Maximus Center for Health Dispute Resolution (MAXIMUS CHDR), that reviews Appeals by enrollees of Medicare-managed care plans, including SecureHorizons Direct<sup>SM</sup>.

**Individual Election Form (IEF)** – The enrollment form a Medicare beneficiary or legal representative must complete (with your signature and date) in order to be enrolled as a SecureHorizons Direct<sup>SM</sup> Enrollee. This form is submitted to CMS for approval. A **Benefit Plan Transfer Application** (also known as an Abbreviated Election Form or short enrollment form) can be used by Enrollees or beneficiary representatives to elect a different benefit plan offered by PLHIC, if available, or when you move from one Service Area to another Service Area. Call Customer Service for more information.

**Limitations** – Items, benefits or services that are limited under the Evidence of Coverage and Schedule of Benefits.

**Medicaid/Medi-Cal** – A joint federal/State medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid/Medi-Cal. Medicaid/Medi-Cal, unlike Medicare, can cover long-term care, such as Custodial Care. Medicaid/Medi-Cal can cover all or part of your Medicare premiums and/or Deductibles and Coinsurance, if your income and resources fall below specific levels. You may inquire about Medicaid/Medi-Cal and related programs: Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, Qualified Individual, by inquiring at your local Department of Social Services.

**Medical Director** – A licensed physician who is an employee of PacifiCare and is responsible for monitoring and overseeing the quality of care to our Enrollees.

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**Medically Necessary or Medical Necessity -**

An intervention will be covered under the PLHIC Health Plan if it is an otherwise covered category of service, not specifically excluded, and *Medically Necessary*: An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity. An intervention is *Medically Necessary* if, as recommended by the treating physician and determined by the Medical Director of PacifiCare it is (all of the following):

- a. A health intervention for the purpose of treating a medical condition;
- b. The most appropriate supply or level of service, considering potential benefits and harms to the Enrollee;
- c. Known to be effective in treating the medical condition. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner which may be provided safely and effectively to the Enrollee. In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- (i) A **health intervention** is an item or service delivered or undertaken primarily to **treat** (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A **medical condition** is a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.

- (ii) **Effective** means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

- (iii) **Scientific evidence** consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Such studies do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first, and to the greatest extent possible, should be the basis for determination of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

- (iv) A **new intervention** is one which is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated

or contradictory, decisions about such new interventions should be based on convincing expert opinion.

- (v) An intervention is considered *cost effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition.

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**Medicare (Original Medicare)** - The federal government health insurance program established by Title XVIII of the Social Security Act for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD).

**Medicare Advantage Private-Fee-For-Service (PFFS) Organization** - A public or private organization licensed by the State as a risk-bearing entity that is under contract with CMS to provide coverage for Covered Services (or to provide health care coverage) to Medicare Eligible Enrollees. Medicare Advantage Private Fee-For-Service Organizations can offer one or more Medicare Advantage Private Fee-For-Service Plans. PacifiCare Life and Health Insurance Company (PLHIC) is a Medicare Advantage Private Fee-For-Service Organization.

**Medicare Advantage Private Fee-For-Service (PFFS) Plan** - A benefit package offered by a Medicare Advantage Private Fee-For-Service Organization that offers a specific set of health benefits at a uniform Health Plan Premium and uniform level of cost-sharing to all people with Medicare who live in the Service Area covered by the Medicare Advantage PFFS Plan. Enrollees under this plan may receive Covered Services from any Deemed Provider. SecureHorizons Direct<sup>SM</sup> is a Medicare Advantage PFFS Plan.

**Medicare Allowable Charges (MAC)** - The amount Medicare has determined is the allowable charges for services provided to Medicare beneficiaries.

**Medicare Eligible Physician** - Physicians are eligible to furnish services to a SecureHorizons Direct<sup>SM</sup> Enrollee if they are state licensed, have Medicare billing numbers or are eligible to obtain one.

**Medicare Part A** - Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

**Medicare Part A Premium** - Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. Generally, people age 65 and older can obtain premium-free Medicare Part A benefits based on their own or their spouse's employment. If you are under 65, you can obtain premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security Administration or the Railroad Retirement Board for more than 24 months. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. Also, you may be able to buy Medicare Part A if you are disabled and lost your premium-free Part A because you are working.

**Medicare Part B** - Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

**Medicare Part B Premium** - A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services whether you are covered by a Medicare Advantage Plan or Medicare.

**Medicare Part D** - The voluntary outpatient prescription drug benefit established by the Medicare Modernization Act of 2003 (MMA). Medicare Part D benefits are not covered by SecureHorizons Direct<sup>SM</sup>. **Medicare Part D Premium** - A monthly premium paid to Medicare Part D providers to cover Part D prescription drug coverage. SecureHorizons

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Direct<sup>SM</sup> benefit plans do not offer Medicare Part D prescription drug coverage and do not include a Medicare Part D Premium.

**Medicare Participating Providers** - Medicare Eligible Physicians, physical therapists, occupational therapists and Durable Medical Equipment suppliers that accept Medicare Allowed Charges as payment in full for services provided to Medicare beneficiaries.

**Medicare Non-Participating Providers** - Medicare Eligible Physicians, physical therapists, occupational therapists and Durable Medical Equipment suppliers that **do not** accept Medicare Allowable Charges as payment in full for services provided to Medicare beneficiaries. The amount that these Providers may bill Medicare beneficiaries is called the Medicare Limiting Charge (115% of the Medicare Allowable Charge).

**Medigap (Medicare supplement insurance policy)** - Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

**Office Visit** - A visit for Covered Services to your Primary Care Physician, Specialist and other Providers.

**Out-of-Pocket Maximum** - The maximum amount that you could pay for Covered Services incurred each Calendar Year. Includes all Copayments, Coinsurance and Part B Excess Charges. Expenses not covered by SecureHorizons Direct<sup>SM</sup> do NOT count toward your annual Out-Of-Pocket Maximum.

**Outpatient Services** - Ambulatory medical services received by an Enrollee while the Enrollee is not admitted to an inpatient or Skilled Nursing Facility.

**PacifiCare Life and Health Insurance Company (PLHIC), "PacifiCare"** - PLHIC is a private organization that is licensed by the State as a risk-bearing entity and that is certified by CMS as meeting Medicare Advantage requirements. PLHIC is a subsidiary company of PacifiCare (PacifiCare Health Systems) and a Medicare Advantage Private Fee-For-Service Organization that offers SecureHorizons Direct<sup>SM</sup> PacifiCare, A UnitedHealthcare Company.

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**Part B Excess Charges** - The amount of charges that Physicians, Providers, physical therapists, occupational therapists and Durable Medical Equipment suppliers may bill Medicare beneficiaries for services provided if these Providers choose to not Accept Medicare Assignment as payment in full. Medicare has established a Medicare Limiting Charge of 115% of Medicare Allowable Charges, which defines the maximum amount that these Providers may bill the beneficiary. You may use Providers who do not Accept Medicare Assignment and will be responsible for paying these Part B Excess Charges. However, Part B Excess Charges count toward your annual Out-of-Pocket Maximum and PLHIC will pay any Part B Excess Charges you incur after the Out-of-Pocket Maximum has been reached.

**Physician** - Any duly licensed Physician, Osteopath, Psychologist or other practitioner (as defined by Medicare) who provides health care services. Physicians are licensed Providers in the United States. See also Primary Care Physician and Specialist.

**Primary Care Physician (PCP)** - Physicians specializing in Internal Medicine, Family Practice, Pediatrics or General Practice. The PCP Copayment, if applicable, can be found in the Schedule of Benefits and Summary of Benefits.

**Provider** - Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State and Medicare to deliver or furnish health care services.

**Quality Improvement Organization (QIO)** - An independent contractor paid by CMS to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. The QIO must review complaints about the quality of care given by physicians in inpatient Hospitals, outpatient Hospital facilities, Hospital emergency rooms, Skilled Nursing Facilities, Home Health Agencies, ambulatory surgical centers and Private Fee-For-Service plans.

**Schedule of Benefits** - The document which provides the details of your particular benefit plan, including any Copayments and Coinsurance

that you should pay when receiving a Covered Service. Together with the Evidence of Coverage, the Schedule of Benefits explains your health care coverage. The **Summary of Benefits** is a CMS-required document that describes many, but not all, of the SecureHorizons Direct<sup>SM</sup> Covered Services.

**SecureHorizons Direct<sup>SM</sup>** - A Medicare Advantage Private Fee-for-Service Plan offered by PacifiCare Life and Health Insurance Company (PLHIC), a Medicare Advantage Private Fee-For-Service Organization.

**Service Area** - A geographic area approved by CMS within which a Medicare Advantage eligible individual must reside in order to enroll in SecureHorizons Direct<sup>SM</sup>. Medicare Advantage Organizations may offer different benefit plans within a Service Area that include different Health Plan Premiums, Covered Services, Copayment and Coinsurance amounts.

**Skilled Nursing Care** - Medically Necessary services that can only be performed by, or under the supervision of, licensed nursing personnel.

**Skilled Nursing Facility (SNF)** - A facility which provides inpatient Skilled Nursing Care, rehabilitation services or other related health services and is State licensed and/or certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged, which furnishes primarily Custodial Care, including training in routines of daily living.

**Specialist** - Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare) who provides health care services for a specific disease, condition or body part. Specialists may also be considered a Primary Care Physician, such as Cardiologists who practice their sub-specialty as well as their Primary Care specialty of Internal Medicine. The Specialist Copayment, if applicable, can be found in the Schedule of Benefits and Summary of Benefits.

**State** - The State in which the Enrollee resides. The State is responsible for licensing and regulating PLHIC.

**Technology Assessment** - PLHIC regularly reviews new procedures, devices, and drugs

to determine whether or not they are safe and efficacious for our Enrollees. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other Terms and Conditions of the plan, including Medical Necessity and any applicable Enrollee Copayments or other payment contributions.

In determining whether to cover a service, PLHIC uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Enrollee, a PacifiCare Medical Director makes a Medical Necessity determination based on individual Enrollee medical documentation; review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

**Terms and Conditions** - Providers agree to be Deemed Providers of Covered Services to Enrollees of SecureHorizons Direct<sup>SM</sup> by being Medicare Eligible and by agreeing to abide by the payment and participation conditions of PLHIC. See Section 4 for more information about Deemed Providers.

**Time-Sensitive** - A situation in which waiting for a standard decision on an authorization, request for services or an Appeal could seriously jeopardize your life, health, or your ability to recover from an illness, injury or condition.

**Urgently Needed Services** - Covered Services that are Medically Necessary and immediately required as a result of an unforeseen illness, injury or condition. Urgently Needed Services are provided in an urgent care facility when your Physician is temporarily unavailable or inaccessible. Covered Services provided by an emergency room Provider are considered Emergency Services, not Urgently Needed Services.

## Section 2

### Eligibility, Enrollment Periods and Effective Date

#### Eligibility

#### To enroll in SecureHorizons Direct<sup>SM</sup>:

- 1) You must be entitled to Medicare Part A and enrolled in Medicare Part B.
- 2) You must not currently have end-stage renal disease or receive routine kidney dialysis. However, if either of these conditions should apply to you, in some instances you may still enroll if you are a current PacifiCare Commercial plan member, either through an employer group sponsored health plan or as an individual. If you develop end-stage renal disease while an Enrollee of SecureHorizons Direct<sup>SM</sup>, you can continue your enrollment under these circumstances. Additionally:
  - If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you are **not** considered to have ESRD and you are eligible to enroll in SecureHorizons Direct<sup>SM</sup>.
  - Individuals with ESRD who are affected by the non-renewal of another Medicare Advantage Organization may make one election to enroll in another Medicare Advantage Organization.
- 3) You must permanently reside in the Service Area as defined in Section 13.
- 4) You must complete and sign an Individual Election Form. If another person assists you in completing the Individual Election Form, that person must also sign the form and state his or her relationship to you.
- 5) You must agree to abide by SecureHorizons Direct<sup>SM</sup> rules.

**If you meet the above eligibility requirements, you cannot be denied enrollment in SecureHorizons Direct<sup>SM</sup> on**

**the basis of your health status, excluding end-stage renal disease as described above.**

#### When You May Enroll in SecureHorizons Direct<sup>SM</sup>

Enrollment in this plan is for the entire year. You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to SecureHorizons Direct<sup>SM</sup> or by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day, seven days a week.

Starting in 2006, there are limits on when and how often you can change the way you get Medicare coverage and what choices you can make when you make the change. For example, if you live in a Service Area that offers more than one benefit plan, switching from one benefit plan to another benefit plan in the same Service Area will count as making a change. Below are some important dates to remember when you consider making a change in the way you get Medicare coverage:

**From November 15, 2005 through May 15, 2006,** anyone with Medicare will have two chances to switch from one way of getting Medicare to another.

**From January 1, 2006 through June 30, 2006,** people with Medicare (including Enrollees of SecureHorizons Direct<sup>SM</sup>) have another chance to make a change to the way they get Medicare coverage. However, if you decide to change your initial 2006 election, you are limited in the type of plan that you can join. You **cannot** join or leave Medicare prescription drug coverage. For example, if you are in a plan that does not offer Medicare drug coverage, you can **only** choose to join another plan that does not offer Medicare prescription drug coverage, or choose to return to Original Medicare without a Medicare Prescription Drug Plan. If you do not have Medicare prescription drug coverage, you cannot use this opportunity to get it.

**From November 15, 2006 through December 31, 2006,** anyone with Medicare can switch from one way of getting Medicare to another for 2007.

**Generally, a Medicare beneficiary cannot make any other changes during 2006**

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**unless he/she meets the following special exceptions:** the Medicare Advantage Plan in which he/she is enrolled is discontinued in the Service Area where he/she lives; the Medicare beneficiary moves out of the Service Area; the Medicare Advantage Organization violates a material provision of its contract with the Medicare beneficiary; or the Medicare beneficiary meets such other material conditions as CMS may provide.

#### **Additional Enrollment Period Information for Newly Eligible Medicare Beneficiaries**

You may elect to enroll in a Medicare Advantage Plan when you first become entitled to both Part A and Part B of Medicare. This enrollment period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B, and ends on the last day of the third month after the date on which you become eligible for both Parts of Medicare. For example: If you are eligible for both Part A and Part B on September 1, you may enroll in SecureHorizons Direct<sup>SM</sup> as early as June 1 but not later than August 31, for a September 1 Effective Date.

#### **Your Enrollment Form**

The SecureHorizons Direct<sup>SM</sup> enrollment form is also referred to as an Individual Election Form (IEF). Once you complete and sign the IEF, it is submitted to CMS for verification of eligibility in SecureHorizons Direct<sup>SM</sup>. If for any reason an IEF is rejected by CMS, PLHIC will contact you for additional information or provide instructions to follow regarding resubmission of the IEF.

#### **When Your SecureHorizons Direct<sup>SM</sup> Coverage Begins**

The Effective Date of enrollment in SecureHorizons Direct<sup>SM</sup> will depend on when PLHIC receives your signed and completed Individual Election Form (IEF) and the enrollment rules. PLHIC will send you a letter that informs you when your coverage begins. When enrollment rules permit, generally, completed IEFs received by the end of the month will be effective the 1st day of the following month. For example, if PLHIC receives your IEF on the 31st of December, your Effective Date is January 1.

#### **Liability of PLHIC Upon Initial Enrollment**

PLHIC is responsible for the full scope of Part B services as required by Medicare, beginning on your Effective Date. However, if your Effective Date occurs during an inpatient stay in a Hospital, PLHIC is not responsible for arranging or paying for any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A). PLHIC must assume responsibility for arranging or paying for inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day following the day of discharge.

#### **If You Want to Change From One Benefit Plan to Another Benefit Plan in Your Service Area (if available)**

In some SecureHorizons Direct<sup>SM</sup> Service Areas you have a choice of benefit plans. Starting in 2006, there are limits on the number of benefit plan changes that you can make during the Calendar Year. Changing from one benefit plan to another benefit plan in your Service Area counts as a change in the way that you get Medicare coverage and you are limited in the choices that you can make. If available in your Service Area, you can choose to join one of our new Premier Plans. Call Customer Service to request a Summary of Benefits and instructions regarding transferring.

Until your Effective Date, you will remain with your previously selected benefit plan. You will continue to receive the benefits that are a part of that benefit plan, as long as you have made any applicable Health Plan Premium payments.

#### **About your Medicare Supplement (Medigap) Policy**

You may consider canceling any Medicare supplement (Medigap) policy you may have after PLHIC has sent you written confirmation of your Effective Date. This is because Health Plan Premiums, Copayments, or other amounts that Medicare Advantage Plans charge for Medicare covered services will not be reimbursed by Medigap policies. However, if you Disenroll from SecureHorizons Direct<sup>SM</sup> you may **not** be able to have your Medigap policy reinstated.

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Note: In certain cases you can be guaranteed the issue (without medical underwriting or preexisting condition exclusions) of a Medicare supplemental (Medigap) policy. Examples of these cases include the following:

- You Disenroll from SecureHorizons Direct<sup>SM</sup> for a reason that does not involve any fault on your part (e.g., you move out of the Service Area or PLHIC's contract with CMS terminates or the Service Area in which you reside is discontinued)
- You enrolled in SecureHorizons Direct<sup>SM</sup> upon first reaching Medicare eligibility at age 65, but Disenroll from SecureHorizons Direct<sup>SM</sup> within 12 months of your Effective Date
- Your supplemental coverage under an employee welfare benefit plan terminates
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no State law provision relating to continuation of coverage
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in SecureHorizons Direct<sup>SM</sup> and you Disenroll during the first twelve (12) months. You will be entitled to purchase the same Medigap policy you had before, if it is still available from the same insurer. If it is not available, you will be entitled to purchase any Medigap Plan "A", "B", "C", or "F" sold in your State. Starting January 1, 2006, you won't be able to buy new Medigap policies with prescription drug coverage because only private companies approved by Medicare will offer Medicare prescription drug coverage.

You must apply for a Medigap policy within sixty-three (63) days after your SecureHorizons Direct<sup>SM</sup> coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 24 hours a day, seven days a week.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive since most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are an Enrollee of SecureHorizons Direct<sup>SM</sup> Original Medicare will not process any claims for medical services that you receive.
- PLHIC has the financial responsibility for all Medicare-covered health services you need as long as you follow SecureHorizons Direct<sup>SM</sup> procedures on how to receive medical services.

## Section 3

### Enrollee Rights and Responsibilities

As an Enrollee you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

#### You Have the Right To:

- Receive information about PacifiCare and the Covered Services under your plan/policy.
- Submit complaints regarding PacifiCare or Deemed Providers or request Appeals for denied service.
- Be treated with dignity and respect and have your right to privacy recognized in accordance with state and federal laws.
- Discuss and actively participate in decision-making with your Deemed Provider regarding the full range of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a Deemed Provider. Your refusal in no way limits or otherwise precludes you from receiving other

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Medically Necessary Covered Services for which you consent.

- Complete an Advance Directive, living will or other directive and provide it to your Deemed Provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your health care.

#### **Your Responsibilities Are To:**

- Review information regarding your benefits, Covered Services, any Exclusions, Limitations, Deductibles or Copayments, and the rules you need to follow as stated in your Evidence of Coverage.
- Provide PacifiCare and Deemed Providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your Deemed Provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for Health Plan Premiums, any other charges owed, and any Copayment or Coinsurance associated with services received while under the care of a Provider or while a patient in a facility.

If you have questions or concerns about your rights, please call Customer Service at the phone number listed on the back of your ID card. If you need help with communication, such as help from a language interpreter, Customer Service representatives can assist you. The Medicare program has written a booklet called Your Medicare Rights and Protection. To get a free copy call 1-800-MEDICARE (1-800-633-4227) or

TTY (1-877-486-2048). Or you can access the Medicare Web site at [www.Medicare.gov](http://www.Medicare.gov) to order this booklet or print it directly from your computer.

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If you think you have been treated unfairly due to your race, color, national origin, disability, age or religion, please call Customer Service. You may also call the Office for Civil Rights.

## **Section 4**

### **How Your SecureHorizons Direct<sup>SM</sup> Coverage Works**

#### **Your SecureHorizons Direct<sup>SM</sup> Identification (ID) Card**

During the time you are an Enrollee, you **must use your SecureHorizons Direct<sup>SM</sup> ID card instead of your red, white and blue Medicare card whenever you get Covered Services.**

Don't discard your Medicare card, however, you must now use your SecureHorizons Direct<sup>SM</sup> ID card to receive Covered Services. If you get services using your Medicare card while you are an Enrollee, the Medicare program will not pay for these services and you may have to pay the full cost yourself. Please carry your SecureHorizons Direct<sup>SM</sup> ID card with you at all times. You will need to show this card at the doctor's office or emergency room.

It is important for you to use only your SecureHorizons Direct<sup>SM</sup> ID card **NOT** your Medicare card:

1. To disclose to a Medicare-eligible Physician your SecureHorizons Direct<sup>SM</sup> enrollment;
2. To make certain your Provider Accepts Medicare Assignment before services are provided (see below for further instructions);
3. To prevent errors in billing. PLHIC pays the bills on behalf of Medicare. Medicare will not pay the bills while you are a SecureHorizons Direct<sup>SM</sup> Enrollee.

If your card is ever damaged, lost or stolen, call Customer Service and they will send you a new one.

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### Selecting A Physician – Deeming Requirements

You may obtain Covered Services from any Medicare Eligible Physician anywhere in the United States. Each time you go to the Physician's office for services, you must:

1. Show your SecureHorizons Direct<sup>SM</sup> Plan ID card.
2. Confirm that your Physician is Medicare eligible, which means that he/she is State licensed, has a Medicare billing number or is eligible to obtain one.
3. Confirm whether your Physician Accepts Medicare Assignment as full payment.
4. Understand whether or not services you are about to receive are Covered Services. If you are at all unsure, you should contact SecureHorizons Direct<sup>SM</sup> at 1-866-272-0407, or for the hearing impaired, (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday, for an Advance Coverage Decision.

A Physician is considered Deemed when the following conditions are met:

1. In advance of furnishing Covered Services, the Physician knows that a patient is enrolled in SecureHorizons Direct<sup>SM</sup>
2. The Physician either possesses or has access to PacifiCare Life and Health Insurance Company's (PLHIC's) Terms and Conditions of payment and participation (which is available by calling the 800 number for providers or at the Web site found on the back of your ID card).
3. The Physician agrees to submit the bill for Covered Services directly to PLHIC for payment.

It is important to note that the Physician has the right to decide whether or not he/she will agree to be a Deemed Provider each time he/she furnishes Covered Services to you.

If the Physician bills you directly for Covered Services, forward the Claim to PLHIC for payment to your Physician for Covered Services, minus your cost-sharing amount.

### Physician Payment

If the Physician informs you that he/she Accepts Medicare Assignment and furnishes Covered Services to you, you are only required to pay the cost-sharing amount allowed by the SecureHorizons Direct<sup>SM</sup> Plan. PLHIC is responsible for the rest of the fee. The Physician who Accepts Medicare Assignment must accept PLHIC's payment as payment in full and may not bill you for any amounts except for your share of costs outlined in the Schedule of Benefits and Summary of Benefits.

If you select a Physician who **does not** Accept Medicare Assignment, you may incur charges in excess of the Medicare Allowable Charges for Covered Services you receive. By law, Physicians who **do not** Accept Medicare Assignment may charge you up to an additional 15% above the Medicare Allowable Charges. These are called Part B Excess Charges. You will be responsible for paying these Part B Excess Charges. However, Part B Excess Charges count toward your annual Out-of-Pocket Maximum and PLHIC will pay any Part B Excess Charges you incur after the Out-of-Pocket Maximum has been reached.

Examples:

**Provider is Deemed and Accepts Medicare Assignment** – You will only be responsible for any Copayment or Coinsurance required for Covered Services rendered. Please refer to your Schedule of Benefits/Summary of Benefits for cost-sharing information.

**Provider is Deemed and does not Accept Medicare Assignment** – You will be responsible for any Copayments or Coinsurance required for Covered Services and may be Balance Billed for Part B Excess Charges.

**Provider is not Deemed** – You may be responsible to pay for all services rendered. Additionally, these charges **do not** apply to your annual Out-of-Pocket Maximum.

When you present your SecureHorizons Direct<sup>SM</sup> ID card at your Physician's office, ask and make certain whether your Physician Accepts Medicare

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Assignment before services are provided. Your Physician is required to disclose to you whether or not he/she Accepts Medicare Assignment.

If a Provider furnishes a service that is not covered by SecureHorizons Direct<sup>SM</sup> to an Enrollee, PLHIC is not required to pay for the service. The Enrollee is responsible for the payment to the Provider.

Remember, each time you go to your Physician, prior to receiving Covered Services, you must notify him/her that you are an Enrollee of SecureHorizons Direct<sup>SM</sup> prior to receiving services.

### **You Can Request an Advance Coverage Decision**

If you would like to make sure that a requested health care service is a Medically Necessary Covered Service, you can ask for an Advance Coverage Decision. Call Customer Service to initiate this request.

## **Section 5**

### **Working with Your Physicians and Providers**

#### **Choosing a Physician**

Your relationship with your Physician is an important one. That is why PLHIC strongly recommends you choose a Physician close to your home or work. Having your Physician nearby makes receiving medical care and developing a trusting and open relationship that much easier. You may choose any Physician who is Medicare Eligible.

Physicians are classified by PLHIC as Primary Care Physicians when they have any of the following specialties:

- General Practice
- Family Practice
- Internal Medicine

Please refer to your Schedule of Benefits/Summary of Benefits for applicable cost-sharing information.

All other Physician specialties will be considered Specialists. You may choose any Specialist who is Medicare Eligible. Please refer to your Schedule of Benefits/Summary of Benefits for applicable cost-sharing information.

Once you have chosen a Physician who agrees to provide health care services to you as a SecureHorizons Direct<sup>SM</sup> Enrollee and has met the Deeming conditions (outlined in Section 4) have all your medical records transferred to his/her office. This will give your Physician access to your medical history, and make him/her aware of any existing health conditions you may have. Please remember that a Physician can at any time decide not to provide health care services to Enrollees of SecureHorizons Direct<sup>SM</sup>. **It is necessary that your Physicians be Deemed each time they provide health care services to you.**

#### **How to Schedule Appointments with your Physician**

To schedule appointments call your Physician's office. Please make sure that you let your Physician know prior to receiving health care services that you are an Enrollee of SecureHorizons Direct<sup>SM</sup> so that he/she can meet the Deeming requirements. See Section 4 for full details.

#### **How to Receive Care After Hours**

If you need to talk to or see your Physician after the office has closed for the day, call his/her office. When the Physician on call returns your call, he or she will advise you on how to proceed.

See Section 6 Emergency and Urgently Needed Services for what to do in cases of an Emergency.

#### **Hospital Care, Skilled Nursing Facility Care and Other Services**

If your Physician determines that you require hospitalization, Skilled Nursing Facility Care, Home Health Agency care, Hospice, Outpatient Services, or acute rehabilitation, he or she will arrange these Medically Necessary Covered Services for you.

## Hospital Care

The term "Hospital" refers to an Acute Care facility and does not include facilities that mainly provide Custodial Care (such as convalescent nursing homes or rest homes). To verify that you are eligible for an inpatient stay, you can request a written Advance Coverage Decision (see Section 4) from PLHIC. Covered Services are listed in the Schedule of Benefits under the heading "Inpatient Hospital Care" and include coverage for the Hospital room, intensive care, definitive observation, isolation, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, surgically implanted devices and implanted breast prosthesis post mastectomy, nursing services, and professional charges by the Hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous Hospital charges for Medically Necessary care and treatment.

Coverage for Acute Care and subacute care includes Medically Necessary inpatient services provided in an Acute Care Hospital, a comprehensive, free-standing acute rehabilitation facility, or a specially designed unit within a Skilled Nursing Facility.

Please note: PLHIC will not pay federal Hospitals, such as Veteran's Administration (VA) Hospitals, for Emergency and non-emergency items and services furnished to veterans, retired military personnel or eligible dependents. However, PLHIC will reimburse Enrollees who are veterans, retired military personnel or eligible dependents for any Copayments or Coinsurance paid to the VA Hospitals for Emergency Services, up to the amount of the SecureHorizons Direct<sup>SM</sup> Emergency Services Copayment. For Enrollees who are not eligible for VA benefits, PLHIC will cover emergency and urgent care provided by a VA facility.

Please refer to the Schedule of Benefits for further details.

Depending upon your benefit plan, Inpatient Hospital care Copayments for each Hospital Stay, if applicable, can be charged on either: 1) a per admission basis, or 2) on a daily basis for a specified number of days. Once you are discharged from a Hospital, any subsequent Hospital admissions, even for the same medical condition at the same Hospital, will require a Hospital Copayment. In certain circumstances, you may be discharged from a Hospital and transferred to a Skilled Nursing Care unit or transitional care unit within the same Hospital. If you are later re-admitted to the Hospital from the Skilled Nursing Care unit or transitional care unit, you will pay the Hospital Copayment. Original Medicare Hospital Benefit Periods do not apply. For inpatient Hospital care, you are covered for an unlimited number of days as long as the Hospital Stay is Medically Necessary.

## Skilled Nursing Facility Care

Skilled Nursing is a level of care ordered by a Physician that must be given or supervised by licensed health care professionals. It can be Skilled Nursing Care, or Skilled Rehabilitation Services such as physical therapy, speech-language pathology services, and occupational therapy. Custodial Care is not covered by SecureHorizons Direct<sup>SM</sup> unless it is provided as other care you are getting in addition to daily Skilled Nursing Care and/or Skilled Rehabilitation Services.

## Other Services

In addition to Physicians, certain other Providers also have the opportunity to charge you Part B Excess Charges. These other Providers include physical therapists, occupational therapists and Durable Medical Equipment suppliers.

Before seeking Covered Services, Providers must be informed that you are enrolled in SecureHorizons Direct<sup>SM</sup> and they must accept PLHIC Terms and Conditions. Hospitals and most other non-Physician providers must accept Medicare Assignment. However, if a non-participating physical therapist, occupational therapist or Durable Medical Equipment supplier does not accept Medicare

Assignment, you may incur expenses **not** covered by SecureHorizons Direct.<sup>SM</sup>

By law, physical therapists, occupational therapists or Durable Medical Equipment suppliers who do **not** accept Medicare Assignment may charge you up to the Medicare Limiting Charge (115% of the Medicare Allowed Charges). You will be responsible for paying these Part B Excess Charges. However, Part B Excess Charges count toward your annual Out-of-Pocket Maximum and PLHIC will pay any Part B Excess Charges you incur after the Out-of-Pocket Maximum has been reached.

When you present your SecureHorizons Direct.<sup>SM</sup> identification card at the physical therapist, occupational therapist or Durable Medical Equipment supplier's office, ask and make certain whether the Provider Accepts Medicare Assignment before services are provided. Your physical therapist, occupational therapist or Durable Medical Equipment supplier is required to disclose to you whether or not he/she Accepts Medicare Assignment. Please refer to Section 4 for more information about the steps to follow to make sure your Provider is a Deemed Provider.

### Ambulance

SecureHorizons Direct.<sup>SM</sup> covers Medically Necessary ambulance services for Emergency or Urgently Needed Services according to Medicare guidelines. Ambulance services are **not covered** when they are:

- Enrollee initiated for social or convenience reasons not primarily medical in nature, including, but not limited to moving to be closer to family, and transferring from one nursing facility to another, while an inpatient in an acute, psychiatric or nursing facility.
- From one facility to another facility, unless necessary to deliver medical services that are not available at the first facility.
- Air Ambulance services for return to the United States from another country.

### Home Health Agency Care Services

If your Physician determines that you require Home Health Agency care, he or she will arrange these Covered Services for you. Home Health Agency care is Skilled Nursing Care and other Medically Necessary therapeutic services that you get in your home for the treatment of an illness or injury when you are confined to your home.

Covered Home Health Agency Services for those who **qualify** may include: part-time or intermittent skilled nursing and home health aide services, physical and occupational therapy and speech-language pathology services, medical social services, medical supplies and Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen, walkers).

When you qualify for coverage of Home Health Agency services, SecureHorizons Direct.<sup>SM</sup> covers either part-time or intermittent skilled nursing and home health aide services in accordance with Medicare guidelines. Part-time or intermittent means any number of days per week up to twenty-eight (28) hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day, based upon the reasonable need for such care.

SecureHorizons Direct.<sup>SM</sup> may cover, subject to review on a case-by-case basis depending on the need for such care, thirty-five (35) or fewer hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day.

A homebound Enrollee has restricted ability, due to an illness or injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home, and consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive

medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the State, or to attend religious services. Home Health Agency services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

## Hospice

Hospice care provides palliative services. It is based on the philosophy that everyone has the right to spend his or her remaining days in peace and with dignity. Hospice focuses on comfort, dignity and pain control, responding to the symptoms, needs and goals of patients and families. Hospice is dedicated to helping the terminally ill live each day to the fullest throughout the dying process, and supporting them to be with their family and friends in a home setting if they wish.

**Hospice care is not a SecureHorizons Direct<sup>SM</sup> Covered Service;** however, PLHIC will cover one (1) Hospice evaluation for Enrollees who have not yet chosen Hospice care to determine if Hospice care is an appropriate health care option.

In order to access Hospice care, Enrollees must elect Hospice care under Medicare. Upon making this election, all care related to the terminal illness will be provided by the Medicare-certified Hospice, which is billed directly to Medicare. Any other Medicare covered services that are not related to the terminal illness will also be billed to Medicare. You may remain enrolled in SecureHorizons Direct<sup>SM</sup> even if you elect Medicare-certified Hospice coverage for your terminal condition. PLHIC will continue to cover non-Medicare-covered benefits which are not related to your Medicare Hospice benefits, provided your Physician is Deemed each visit, as per Section 4.

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you have the right to obtain information about all available Medicare-certified Hospice Providers.

If you are interested in using Hospice services, you can call 1-800-MEDICARE (1-800-633-4227;

TTY 1-877-486-2048), 24 hours a day, seven days a week or visit the Medicare Web site at [www.medicare.gov](http://www.medicare.gov) and get a free copy of the "Medicare Hospice Benefits" booklet that lists Medicare-certified Hospice programs in your area.

## Clinical Trials

A "clinical trial" is a way of testing new types of medical care, such as new cancer drugs. If you participate as a patient in a clinical trial that meets Medicare requirements, Medicare covers routine costs of qualifying clinical trials. **Clinical trials are not SecureHorizons Direct<sup>SM</sup> Covered Services.**

If you join a clinical trial, you will be responsible for any Coinsurance under Medicare. When you enroll in a clinical trial, the Providers are paid directly by Medicare for all the Covered Services you receive. The clinical trial Providers do not have to be Deemed Providers.

If you participate in a clinical trial, you may stay enrolled in SecureHorizons Direct<sup>SM</sup> and continue to get the rest of your care that is unrelated to the clinical trial through SecureHorizons Direct<sup>SM</sup>.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (TTY 1-800-633-4227) 24 hours a day, seven days a week, or visit [www.medicare.gov](http://www.medicare.gov) on the Internet.

## Religious Non-medical Health Care Institutions (RNHCIs) Care

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by PLHIC under certain conditions. Covered Services in a RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient Hospital care or extended care services, or care through a Home Health Agency. You may get services when furnished in the home, but only items and services ordinarily furnished by Home Health Agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.)

## Organ Transplants

### 1. Organ Transplant Definitions

- **Donor:** A person who undergoes a surgical procedure for the purpose of donating either a body organ or body tissue for transplant procedure.
- **Histocompatibility Testing:** Testing that involves matching or typing of the human leukocyte antigen in preparation for organ or tissue transplant.
- **Regional Organ Procurement Agency:** An organization designated by the federal government and responsible for the procurement of organs for transplantation and the promotion of organ donation.

### 2. Transplant Services

Human organ and tissue transplants are limited to non-experimental/non-investigational procedures that are determined to be Medically Necessary. Coverage is provided at Medicare-approved facilities through Medicare-certified programs for the medical, surgical and Hospital services required for pre-transplant, transplant and post-transplant. You can (but are not required to) call Customer Service for an Advance Coverage Decision for transplant services. Examples of covered transplant services include:

- Heart
- Lung
- Heart/lung
- Liver
- Kidney
- Simultaneous pancreas/kidney
- Pancreas transplant after kidney
- Intestinal and multivisceral
- Cornea

- Allogeneic bone marrow or stem cell
- Autologous bone marrow or stem cell

PLHIC shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered transplants should be revised.

**Bone Marrow and Stem Cell Transplants:** The testing of immediate blood relatives to determine compatibility of bone marrow and stem cells is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Enrollee is the intended recipient. There is no dollar limitation for Medically Necessary donor related clinical transplant services once a donor is identified.

### 3. Organ Procurement, Transplant and Transplant Services

Coverage of services shall include:

- Pre-transplant testing and evaluation, including histocompatibility testing of transplant recipient and non-related or related donor.
- Organ procurement from cadaver or live donor and organ transportation. Covered Services for living donor are limited to Medically Necessary services once a donor is identified.
- Oral or dental examination performed on an inpatient basis as part of comprehensive evaluation work-up prior to transplant procedure.
- When the transplant recipient is an Enrollee, reasonable and necessary Hospital services of the donor solely for the transplant procedure are covered (the donor does not need to be an Enrollee).
- Services and/or charges related to a national donor search.
- Outpatient, post-transplant, immunosuppressive drug therapy. (Please see your Schedule of Benefits.)

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

## Behavioral Health Benefits

Your health plan also covers your need for mental health and chemical dependency issues, according to Medicare guidelines.

### 1. Outpatient Visits

SecureHorizons Direct<sup>SM</sup> Enrollees may also obtain outpatient behavioral health services from any Provider who accepts Medicare and PLHIC Terms and Conditions of payment.

### 2. Inpatient Stays

Inpatient stay benefits are only available when your Physician or behavioral health Provider can help you arrange for this Medically Necessary care (as defined by Medicare). To verify that you are eligible for an inpatient stay, you can request a written Advance Coverage Decision from PLHIC.

### 3. What Happens in an Emergency?

In the event of a Behavioral Health emergency, go to the closest emergency room or call 911. PLHIC will cover Emergency Services according to Medicare guidelines. Ambulance Services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life. You can go to any provider for Emergency Services. Refer to Section 6 for more information on Emergency and Urgently Needed Services.

### 4. What Do I Do if I Receive a Bill?

If you receive a bill please mail it to:

SecureHorizons Direct<sup>SM</sup> Claims Department  
P.O. Box 4169  
Scranton, PA 18505

If you have a Copayment or Coinsurance, you are responsible to pay these directly to the Provider.

## Section 6

### Emergency and Urgently Needed Services

**Emergency Services – Prior approval (i.e., an Advance Coverage Decision) from PLHIC is not necessary for treatment of Medical Emergencies.**

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

### What is An Emergency Medical Condition?

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the Enrollee's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part. In the case of a pregnant woman, an Emergency Medical Condition exists if the Enrollee is in Active Labor, meaning labor at a time at which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or b) a transfer may pose a threat to the health and safety of the Enrollee or the unborn child.

**Emergency Services are covered inpatient or outpatient services that are:**

1. **Furnished by a Provider qualified to provide Emergency Services; and**
2. **Needed to evaluate or stabilize an Emergency Medical Condition.**

### What To Do in an Emergency?

In the event of an Emergency Medical Condition, go to the closest emergency room or call 911 for assistance. PLHIC will cover Emergency Services worldwide. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life. Please note that Emergency Services coverage is the same whether you obtain services within or outside of the Service Area. If you have an Emergency Medical Condition, the emergency Provider does not need to be a Deemed Provider prior to receiving Covered Services. If you have an Emergency Medical Condition, you should contact your Physician within 48 hours, or as soon as reasonably possible after the emergency, so he/she can arrange any necessary follow-up care.

**What is covered if you have an Emergency Medical Condition?**

- You are covered for Emergency Services no matter where you are in the world.
- Ambulance or other emergency transportation services are covered in emergency situations.

**What are "Urgently Needed Services"?**

- Urgently Needed Services are Covered Services that are Medically Necessary and immediately required as a result of an unforeseen illness, injury or condition. Urgently Needed Services are provided in an urgent care facility when your Physician is temporarily unavailable or inaccessible.
- This is different from an Emergency Medical Condition. Covered Services provided by an emergency room Provider are considered Emergency Services, not Urgently Needed Services.

If you require Urgently Needed Services and go to an urgent care facility, the urgent care Provider does not need to be Deemed Provider prior to receiving Covered Services.

You are covered for Urgently Needed Services no matter where you are in the world.

**Reimbursement for Emergency and Urgently Needed Services Paid by an Enrollee.**

Enrollees should submit bills to PLHIC for payment at the following address:

SecureHorizons Direct<sup>SM</sup> Claims Department  
P.O. Box 4169  
Scranton, PA 18505

If you have questions about any bills, contact Customer Service.

**Right to Appeal**

PLHIC provides you with a written notice if a service or payment is denied. If PLHIC has denied payment for services you think should have been covered, you have the right to appeal. Please refer to Section 8 of this Evidence of Coverage (Organization Determination, Appeals and Grievance Procedures) for more information.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

**Section 7****Premiums and Payments**

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you will be financially responsible for the monthly Health Plan Premium (if applicable), as well as Copayments and Coinsurance amounts that are listed in the Schedule of Benefits. You must also continue to pay your Medicare Part A and Part B Premiums, if applicable.

- **SecureHorizons Direct<sup>SM</sup> Health Plan Premium** - Your monthly Health Plan Premium is listed in the Schedule of Benefits and is due on the first of each month. Not all SecureHorizons Direct<sup>SM</sup> plans have a Health Plan Premium.
- **Medicare Part A Premium** - Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A, and you have purchased Part A through Social Security, you must continue to pay your Medicare Part A Premium. If you would like to purchase Part A from Social Security, please call your local Social Security Administration Office or call 1-800-772-1213. For the hearing impaired the toll-free number to reach Social Security Administration is 1-800-325-0778.
- **Medicare Part B Premium** - A monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). As a SecureHorizons Direct<sup>SM</sup> Enrollee, you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is usually automatically deducted from your check. Otherwise, the premium is paid directly to Medicare by you or someone on your behalf (such as Medicaid/Medi-Cal).

**What Happens if You Don't Pay Your Health Plan Premiums?**

PLHIC has the right to Disenroll you from SecureHorizons Direct<sup>SM</sup> for failure to pay Health Plan Premiums. However, prior to such action, PLHIC will:

- (a) Contact you within twenty (20) days after the date of the delinquent charges are due,
- (b) Advise you that failure to pay Health Plan Premiums within a thirty (30) day grace period may result in your Disenrollment, and
- (c) Include an explanation of your rights under the Grievance procedures.

Should you decide later to re-enroll in SecureHorizons Direct<sup>SM</sup> or to enroll in another plan offered by PLHIC, you may be required to pay any outstanding Health Plan Premiums due from your previous enrollment in SecureHorizons Direct<sup>SM</sup>.

**Until you are notified of your Disenrollment, you will continue to be a SecureHorizons Direct<sup>SM</sup> Enrollee.**

For details on Disenrollment for non-payment of Health Plan Premiums, see Section 9.

### **Your Premium Payment Options**

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you have three (3) options for paying your Health Plan Premium, if applicable (please see your Schedule of Benefits to determine if you have a Health Plan Premium).

Your options are the:

1. EasyPay method,
2. Billing Payment method,
3. Premium Withhold method.

### **EasyPay Method**

With the convenient EasyPay method, you can have your Health Plan Premium automatically deducted from your personal checking account and electronically transmitted for payment or, starting in 2006, automatically charged to your credit card. You will have no more checks to write, and can enjoy peace of mind knowing that your Health Plan Premium payments are taken care of, even if you are traveling.

Call Customer Service and ask for an **EasyPay Automatic Health Plan Premium Request form** if you would like to use this option. Once we receive the form back, you will receive a letter

confirming the date and amount of the Health Plan Premium that will be debited from your account or charged to your credit card. You must contact Customer Service if there are any changes to your checking or credit card account information.

For EasyPay through your checking account, you will be notified of your initial deduction at least 10 days prior to the transaction date. All subsequent Health Plan Premium payment deductions will be reflected on the statement from your financial institution. Your bank account must have the full dollar amount due in available funds in order for the preauthorized payment to be made. If there are insufficient funds in your account, your bank will return the preauthorized payment and may charge you just as if you had a check returned for the same reason.

The authorization you provide for PLHIC to automatically arrange payment will remain in effect until you cancel it with written notice to: SecureHorizons Direct<sup>SM</sup> P.O. Box 4169, Scranton, PA 18505.

### **Billing Payment Method**

If you do not elect the EasyPay method of payment or the Premium Withhold method, you will be automatically enrolled in the Billing Payment method. Using the Billing Payment method is simple. As Health Plan Premiums become due, you will receive a billing statement from PLHIC. Complete a check or money order for the amount shown on the billing statement and mail it in the envelope provided.

Both the EasyPay and Billing Payment methods are available on a monthly, quarterly, semi-annual and annual basis.

### **Premium Withhold Method**

New in 2006, you can choose to have your SecureHorizons Direct<sup>SM</sup> Health Plan Premium, if any, withheld from your monthly check received from the Social Security Administration. You may elect this option upon enrollment in SecureHorizons Direct<sup>SM</sup> or after enrolling by requesting a Premium Withhold Form from Customer Service.

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(Note: in the near future the Federal Government will also permit the Premium Withhold from monthly benefits received from the Railroad Retirement Board and the Office of Personnel Management; however, as of this printing, these options are not yet available.)

If you have any questions regarding your Health Plan Premium payment choices, please call Customer Service.

### **Changes in Health Plan Premiums**

Increases in Health Plan Premiums and/or decreases in your level of coverage are only allowed at the beginning of each contract year (which is based on the Calendar Year). These changes must be approved by CMS. There will be no benefit changes during the contract year unless they are to your advantage. You will receive a written notice in the fall of any changes for the new contract year.

## **Section 8**

### **Organization Determination, Appeal and Grievance Procedures**

As a SecureHorizons Direct<sup>SM</sup> Enrollee you are encouraged to let PLHIC know if you have concerns or experience any problems with PLHIC or SecureHorizons Direct<sup>SM</sup>. PLHIC has representatives available to help you with your questions and concerns. The procedures described in this section may be used if you have an Appeal or Grievance you want PLHIC to review.

**Organization Determinations** are defined as the decision PLHIC makes on your request for the provision of services or payment of Claims. Organizational Determinations include Advance Coverage Decisions.

**Advance Coverage Decisions** – To verify that a health care service is a Medically Necessary Covered Service, you can request a written Advance Coverage Decision from Customer Service.

**Appeals** are defined as the type of complaint you make when you want a reconsideration of a decision that was made regarding a service or the amount of payment PLHIC pays or will pay for a

service. You may file an Appeal for the following reasons:

- PLHIC refuses to cover or pay for services you think PLHIC should cover.
- PLHIC or a Deemed Provider refuses to give you a service you think should be covered.
- PLHIC or a Deemed Provider reduces or cuts back on services you have been receiving.
- If you think that PLHIC is stopping your coverage too soon.

**Grievances** are defined as the type of complaint you make if you have any other type of problem (other than an Appeal) with PLHIC or a Provider. You would file a Grievance if you have a problem with things such as:

- the quality of your care
- general dissatisfaction with the way SecureHorizons Direct<sup>SM</sup> benefits are designed
- waiting times for appointments or in the waiting room
- the way your doctors or others behave
- being unable to reach someone by phone or obtain the information you need
- the lack of cleanliness or condition of the doctor's office.

If either your Appeal or Grievance involves a clinical issue, a medical reviewer who has the education, training and relevant expertise that is pertinent to evaluate the specific clinical issues that serve as the basis of your complaint, will review it.

### **Organization Determinations**

PLHIC or your Physician must make a determination (decision) on your request for the provision of services or payment of Claims within the following timeframes:

#### **■ Request for Services (Advance Coverage Decision)**

If you request services, PLHIC must make a decision as expeditiously as your health care requires, but no later than fourteen (14)

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calendar days after receiving your request for service. An extension up to fourteen (14) calendar days is permitted, if you request the extension or if PLHIC finds that additional information is needed that will benefit you. When PLHIC takes an extension, you will be notified of the extension in writing.

■ **Requests for Payment (Claims)**

If you request payment for services you have already received, PLHIC must make a decision on whether or not to pay the Claim no later than sixty (60) calendar days from receiving your request.

PLHIC must notify you in writing of any organization determination denial decision (partial or complete) within the timeframes listed above. The notice must state the reasons for the denial, inform you of your right to a standard and expedited reconsideration (Appeal) process, and the right to appoint a representative to file an Appeal on your behalf. You also have the right to submit additional information regarding the requested service in writing or in person. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) calendar days of a request for payment, you may assume the decision is a denial, and you may file an Appeal.

**Expedited/72-Hour Organization Determination Procedures (Advance Coverage Decision)**

You have the right to request and receive expedited determinations affecting your medical treatment in Time-Sensitive situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function. If PLHIC or your Physician decides, based on medical criteria, that your situation is Time-Sensitive or if PLHIC or any physician calls or writes in support of your request for an expedited review, PLHIC or your Physician will issue a decision as expeditiously

as possible, but no later than seventy-two (72) hours after receiving the request. PLHIC or your Physician/Provider may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if PLHIC or your Physician needs additional information, and the extension of time benefits you. If the timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension. You will be notified promptly of the organization determination, but no later than upon expiration of the extension.

If you believe you need a service and you believe it is a Time-Sensitive situation, you or any physician, including a physician with no connection to PLHIC, may request that the decision be expedited. If PLHIC or your Physician decides that it is a Time-Sensitive situation or if any physician indicates that applying the standard timeframe for making a determination could seriously jeopardize your life or health or your ability to regain maximum function, PLHIC will make a decision on your request for a service on an expedited/72-hour basis (subject to extension as discussed below).

To request an Expedited/Seventy-Two (72)-Hour organization determination you or your authorized representative may call PLHIC or your Physician. **Be sure to ask for an expedited seventy-two (72)-hour review when you make your request.**

**How Your Expedited/72-Hour Organization Determination Request Will Be Processed**

1. Upon receiving your request, PLHIC or your Physician will determine if your request meets the definition of Time-Sensitive.
  - If your request does not meet the definition, it will be handled within the standard review timeframe (fourteen (14) calendar days for organization determinations). You will be informed by telephone that your request for the expedited seventy-two (72)-hour review has been denied. You will also receive a written confirmation that the request will

be processed within the standard review timeframe: within three (3) calendar days of the telephone call. If you disagree with PLHIC's or your Physician's decision to process your request within the standard timeframe, you may file an expedited Grievance with PLHIC. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of PLHIC's or your Physician's decision within seventy-two (72) hours. You will also receive a follow-up letter within three (3) calendar days of the phone call.

2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/seventy-two (72)-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function.
3. PLHIC or your Physician will make a decision and notify you of it within seventy-two (72) hours of receipt of your request. If PLHIC or your Physician does not approve your request, you can Appeal to PLHIC (see below).

There are four possible dispositions to a request for an expedited organization determination:

- Your request to expedite an organization determination decision is accepted, PLHIC or your Physician makes a decision in seventy-two (72) hours and notifies you that the services will be covered.
- Your request to expedite an organization determination decision is accepted, PLHIC or your Physician makes a decision in seventy-two (72) hours and notifies you that the services will **not** be covered, and you can Appeal to PLHIC.
- Your request to expedite the organization determination decision is **not** accepted, and PLHIC or your Physician informs you that your request will be handled under the standard organization determination process.

- Your request to expedite an organization determination decision cannot be made in seventy-two (72) hours, and PLHIC or your Physician informs you that they will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Customer Service.

### **General Information on the Medicare Appeals Process**

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you have the right to Appeal any organization determination about a requested health care service or PLHIC's payment for, or what you believe are Covered Services under SecureHorizons Direct<sup>SM</sup>. These include the following:

- Payment for out-of-area renal dialysis and routine travel dialysis services, Emergency Services or Urgently Needed Services;
- Services you have not received, but you believe are the responsibility of PLHIC to pay for or arrange;
- Discontinuation of services you believe are Medically Necessary Covered Services; or
- Failure of PLHIC to approve or provide payment for health care services in a timely manner or to provide you with a timely notice of an adverse determination, such that a delay would adversely affect your health.

Use the Appeal procedure when you want a reconsideration of a decision (organization determination) that was made regarding a service or the amount of payment PLHIC paid for a service.

Use the Grievance procedure for any complaints or other disputes that are not denied Claims or denied services subject to organization determination as explained above. If you have a question about which complaint process to use, please call Customer Service.

PLHIC is required to track all Appeals and Grievances in order to report cumulative data to CMS and to SecureHorizons Direct<sup>SM</sup> Enrollees upon request.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

## Who May File an Appeal

1. You may file an Appeal.
2. Someone else may file the Appeal for you on your behalf. You may appoint an individual to act as your representative to file the Appeal for you by following the steps below:
  - a) Provide PLHIC with your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may appoint a physician or a Provider.) For example: "I \_\_[your name]\_\_ appoint \_\_[name of representative]\_\_ to act as my representative in requesting an Appeal from PLHIC and/or CMS regarding the denial or discontinuation of medical services."
  - b) You must sign and date the statement.
  - c) Your representative must also sign and date this statement unless he or she is an attorney.
  - d) You must include this signed statement with your Appeal.

## Support for Your Appeal

You are not required to submit additional information to support your request for reconsideration (Appeal). PLHIC is responsible for gathering all necessary medical information. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your Appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Provider. If your medical records from a Specialist are not included in your medical records from this Provider, you may need to submit a separate request to the Specialist who provided medical services to you.

## Assistance with an Appeal

Regardless whether you request a standard or expedited Appeal, you can have a friend, lawyer or someone else help you. There are lawyers who do not charge unless you win your Appeal. Groups such as lawyer referral services can help

you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

## Standard Appeal Procedures

If you decide to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

1. You must submit a written request for reconsideration to the PLHIC Appeals and Grievance Unit at: P.O. Box 400046, San Antonio, TX 78299. You must submit your written request within sixty (60) calendar days of the date of the notice of the initial organization determination.

Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day timeframe.

2. PLHIC will conduct a reconsideration and notify you in writing of the decision within thirty (30) days, if the Appeal is for a request for a denied service. Note that PLHIC must notify you of the reconsideration decision as expeditiously as possible, but no later than thirty (30) calendar days from receipt of your request. PLHIC may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if PLHIC finds that additional information is needed and the extension of time benefits you.

If the Appeal is for a denied Claim, PLHIC must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.

PLHIC's reconsideration decision will be made by a person(s) not involved in the initial decision. A physician must make all reconsiderations of adverse organization determinations based on Medical Necessity with expertise in the field of medicine that is appropriate for the service at issue. However, that physician need not be of the same specialty or subspecialty as the treating physician.

3. If PLHIC decides to reverse the original adverse decision, PLHIC must authorize or arrange your service as expeditiously as your health requires, but no later than thirty (30) calendar days from the date PLHIC received your request for an Appeal; or PLHIC will pay your Claim within sixty (60) calendar days of your request for an Appeal.
4. If PLHIC decides to uphold the original adverse decision, either in whole or in part, or if PLHIC fails to provide you with a decision on your reconsideration within the relevant timeframe, PLHIC will automatically forward the case to an Independent Review Entity for a new and impartial review and you will be notified. PLHIC must send the Independent Review Entity the file within thirty (30) days of a request for services and within sixty (60) days of a request for payment. The Independent Review Entity will either uphold PLHIC's decision or issue a new decision. If PLHIC forwards the case to the Independent Review Entity, PLHIC still must notify you of the decision within the relevant timeframe discussed above.
5. For cases submitted to an Independent Review Entity for review, the Independent Review Entity will make a reconsideration decision and notify you in writing of their decision and the reasons for the decision. **If the Independent Review Entity decides in your favor and reverses PLHIC's decision, the following must occur:**

**Request for Service:** If the Independent Review Entity decides in your favor, PLHIC must authorize the service under dispute within seventy-two (72) hours from the date of receipt of the Independent Review Entity's notice reversing PLHIC's decision or provide the service under dispute as expeditiously as your health condition requires, but no later than fourteen (14) calendar days from date of receipt of the Independent Review Entity's notice.

**Request for Payment:** If the Independent Review Entity decides in your favor, PLHIC must pay for the service no later than thirty (30) calendar days from the date of the Independent Review Entity's notice. If the Independent Review Entity maintains PLHIC's decision, their notice will inform you of your right to a hearing before an administrative law judge (ALJ) of the Social Security Administration.
6. You may request a hearing before an administrative law judge (ALJ) by submitting a written request to PLHIC, CMS or the Social Security Administration within sixty (60) days of the date of the Independent Review Entity's notice that the reconsideration decision was not in your favor. This sixty (60)-day notice may be extended for good cause. A hearing can be held only if the amount in controversy meets the dollar requirement (at least \$110 in 2006). All hearing requests will be forwarded to the Independent Review Entity. The Independent Review Entity will then forward your request and your reconsideration file to the hearing office. PLHIC will also be made a party to the Appeal at the ALJ level.
7. If the administrative law judge's decision is adverse, either you or PLHIC may request a review by the Medicare Appeals Council (MAC) of the Social Security Administration, which may either review the decision or decline review. If the administrative law judge decides in your favor, PLHIC must pay for the service you have asked for within 60 calendar days from the date PLHIC receives notice of the decision. However, if PLHIC appeals this decision by asking for a review by the MAC, PLHIC may await the MAC's decision before complying with the decision of the ALJ.
8. If the dollar value of your contested medical care meets the dollar requirement (at least \$1,090 in 2006), either you or PLHIC may request that a decision made by the MAC or the ALJ if the MAC has declined review, be reviewed by a federal district court.
9. Any initial or reconsidered decision made by PLHIC, an Independent Review Entity, the ALJ or the MAC can be reopened: (a) within twelve (12) months; (b) within four (4) years for just cause; or (c) at any time for clerical correction or in cases of fraud.

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10. Independent Review Entity Reopenings: A reopening is not an Appeal right. Any of the parties to a reconsideration determination may request a reopening, however granting a reopening is solely at the Independent Review Entity's discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made. All Independent Review Entity decisions advise the parties of the standards for reopening of the case by the Independent Review Entity. Any party to the determination may request a reopening if the party believes one of the following grounds for reopening is applicable:

- Error on the face of the evidence by the Independent Review Entity in its review
- Fraud
- New and additional information that was not available at the time the Independent Review Entity made its initial decision in the case

A Medicare Advantage Organization's request for a reopening does not relieve the Medicare Advantage Organization of the responsibility to comply with the Independent Review Entity's decision within the required timeframes.

However, if the Independent Review Entity's decision at the conclusion of the reopening review is unfavorable to you, you will be liable for the cost of the care rendered.

11. The reconsidered decision is final and binding upon PLHIC. The binding arbitration clause in your Individual Election Form does not apply to disputes subject to CMS's Appeals process.

### **Expedited/72-Hour Appeal Procedures**

You have the right to request and receive an expedited seventy-two (72)-hour reconsideration (Appeal) in situations where waiting for a reconsideration (Appeal) decision to be made within the standard timeframe could seriously jeopardize your life or health, or your ability to regain maximum function. If PLHIC decides, based on medical criteria, that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited reconsideration (Appeal) review, PLHIC will

issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. PLHIC may extend this timeframe by up to fourteen (14) days if you request the extension or if PLHIC needs additional information, and the extension of time benefits you. If the reconsideration (Appeal) timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension. You will be notified promptly of PLHIC's decision, but no later than upon expiration of the extension.

If you wish to request a reconsideration (Appeal) of a decision by PLHIC to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service and you believe it is a Time-Sensitive situation, you or your authorized representative may request that the reconsideration (Appeal) be expedited. If a physician wishes to file an expedited Appeal for you, you must give him or her authorization to act on your behalf. If PLHIC or any physician decides that it is a Time-Sensitive situation, PLHIC will make a decision on your Appeal on an expedited seventy-two (72)-hour basis. Examples of service decisions which you may Appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:

- If you received a denial of a service you requested;
- If you think you are being discharged from any of the following too soon and you have missed the deadline for a Quality Improvement Organization (QIO) review:
  - Hospital
  - Skilled Nursing Facility (SNF)
  - Home Health Agency (HHA)
  - Comprehensive Outpatient Rehabilitation Facility (CORF)

The procedures for requesting and receiving an expedited Appeal are described in the following sections.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

### **How to Request an Expedited Reconsideration**

To request an expedited seventy-two (72)-hour review, you or your authorized representative may call, write, fax or visit PLHIC. **Be sure to ask for an expedited seventy-two (72)-hour review when you make your request.**

Call:

1-866-272-0407

(hearing impaired, 1-888-844-5530)

Business Hours: Monday through Friday,  
8 a.m. – 10 p.m. EST

PLHIC will document your request in writing.

Write:

PLHIC Appeals and Grievance Unit

P.O. Box 400046

San Antonio, TX 78299

Fax:

1-888-615-6584

Attention: Appeals and Grievance Unit

Business Hours: Monday through Friday,  
8 a.m. – 8 p.m. CST

Walk-in:

PacificCare Customer Service Center

6200 Northwest Parkway

San Antonio, TX 78249-3348

Business Hours: Monday through Friday,  
8 a.m. – 5 p.m. CST

### **How Your Expedited/72-Hour Reconsideration Request will be Processed**

1. Upon receiving your reconsideration request, PLHIC will determine if your request meets the definition of Time-Sensitive.
  - If your request does not meet the definition, it will be handled within the standard review process (thirty (30) days for Appeals). You will be informed by telephone that your request for the expedited seventy-two (72)-hour Appeal review has been denied and will also receive a written confirmation that the request will be processed within the standard review timeframe: within three (3) calendar days of the telephone call. If you disagree with PLHIC's decision to process your request

within the standard timeframe, you may file a Grievance with PLHIC. The written confirmation letter will include instructions on how to file an expedited Grievance. If your request is Time-Sensitive, you will be notified of PLHIC's Appeal decision within seventy-two (72) hours. You will also receive a follow-up decision letter within three (3) calendar days of the telephone call.

- An extension up to fourteen (14) calendar days is permitted for a seventy-two (72)-hour Appeal if the extension of time benefits you, for example, if you need time to provide PLHIC with additional information or if PLHIC needs to have additional diagnostic testing completed. PLHIC will make a decision as expeditiously as your health requires, but no later than the end of any extension period. If the timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file an expedited Grievance should you disagree with an extension.
2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/ seventy-two (72)-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function.
  3. PLHIC will make a decision on the Appeal and notify you of it within seventy-two (72) hours of receipt of your request. If PLHIC decides to uphold the original decision, either in whole or in part, PLHIC will forward the entire file to the Independent Review Entity for review no later than twenty-four (24) hours after PLHIC's decision. The Independent Review Entity will send you a letter with their decision within seventy-two (72) hours of receipt of your case from PLHIC, or at the end of the fourteen (14)-day extension.

There are four (4) possible dispositions to a request for expedited Appeals:

- Your request to expedite an Appeal decision is accepted, PLHIC makes a decision in seventy-

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two (72) hours and notifies you that the services will be covered.

- Your request to expedite an Appeal decision is accepted, PLHIC makes a decision in seventy-two (72) hours and notifies you that the services will not be covered, and the case will be sent to the Independent Review Entity for determination within twenty-four (24) hours.
- Your request to expedite an Appeal decision is **not** accepted, and PLHIC informs you that your request will be handled under the standard Appeal process.
- Your request to expedite an Appeal decision cannot be made in seventy-two (72) hours, and PLHIC informs you that PLHIC will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Customer Service.

### **Information You Should Receive During Your Hospital Stay**

When you are admitted to the Hospital, someone at the Hospital should give you a notice called the *Important Message from Medicare*. This notice explains your rights under the law. When a doctor decides that you are ready to leave the Hospital (to “be discharged”), and if you believe you should not be discharged yet, you should be given a copy of another notice that includes specific information about your Hospital discharge. This other notice is called the *Notice of Discharge and Medicare Appeal Rights*. It will tell you:

- Why you are being discharged.
- The date that we will stop covering your Hospital stay, also known as the “last covered day” (the date when PLHIC will stop paying our share of your Hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

As an Enrollee you should receive this information about your discharge **before** you leave the Hospital. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the Hospital — it only means that you received the notice. If you do not receive the notice after you have told the Hospital that you think you are being discharged too soon, ask for the *Notice of Discharge and Medicare Appeal Rights* immediately.

### **Quality Improvement Review**

If you are in the Hospital and you think that you are being discharged too soon, you have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge and Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization (QIO) to review whether your discharge is medically appropriate.

The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of PLHIC or your Hospital. There is one QIO in each State. QIOs have different names, depending on which State they are in.

For the name and phone number of the QIO for your area, please find your State in the QIO Chart below, contact Customer Service or go to [www.medqic.org](http://www.medqic.org) on the Internet. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their Hospital stay is ending too soon.

**Quality Improvement Organizations (QIOs) Chart**

| <b>State</b>                | <b>Organization Name</b>                    | <b>Telephone Number</b> | <b>Web site Link</b>                                                       |
|-----------------------------|---------------------------------------------|-------------------------|----------------------------------------------------------------------------|
| <b>Alabama</b>              | Alabama Quality Assurance Foundation        | 205-970-1600            | <a href="http://www.aqaf.com">www.aqaf.com</a>                             |
| <b>Alaska</b>               | Qualis Health                               | 800-878-7170            | <a href="http://www.qualishealth.org">www.qualishealth.org</a>             |
| <b>Arizona</b>              | Health Services Advisory Group              | 602-264-6382            | <a href="http://www.hsaq.com">www.hsaq.com</a>                             |
| <b>Arkansas</b>             | Arkansas Foundation for Medical Care        | 877-375-5700            | <a href="http://www.afmc.org">www.afmc.org</a>                             |
| <b>California</b>           | Lumetra                                     | 800-841-1602            | <a href="http://www.lumetra.com">www.lumetra.com</a>                       |
| <b>Colorado</b>             | Colorado Foundation for Medical Care        | 303-695-3300            | <a href="http://www.cfmc.org">www.cfmc.org</a>                             |
| <b>Connecticut</b>          | Qualidigm                                   | 860-632-2008            | <a href="http://www.qualidigm.org">www.qualidigm.org</a>                   |
| <b>Delaware</b>             | Quality Insights of Delaware                | 800-422-8804            | <a href="http://www.qide.org">www.qide.org</a>                             |
| <b>District of Columbia</b> | Delmarva Foundation for Medical Care        | 202-293-9650            | <a href="http://www.delmarvafoundation.org">www.delmarvafoundation.org</a> |
| <b>Florida</b>              | Florida Medical Quality Assurance           | 813-354-9111            | <a href="http://www.fmqai.com">www.fmqai.com</a>                           |
| <b>Georgia</b>              | Georgia Medical Care Foundation             | 404-982-0411            | <a href="http://www.gmcf.org">www.gmcf.org</a>                             |
| <b>Hawaii</b>               | Mountain-Pacific Quality Health Foundation  | 800-524-6550            | <a href="http://www.mpqhf.org">www.mpqhf.org</a>                           |
| <b>Idaho</b>                | Qualis Health                               | 800-488-1118            | <a href="http://www.qualishealth.org">www.qualishealth.org</a>             |
| <b>Illinois</b>             | Illinois Foundation for Quality Health Care | 800-386-6431            | <a href="http://www.ifqhc.org">www.ifqhc.org</a>                           |
| <b>Indiana</b>              | Health Care Excel                           | 800-300-8190            | <a href="http://www.hce.org">www.hce.org</a>                               |
| <b>Iowa</b>                 | Iowa Foundation for Medical Care            | 800-383-2856            | <a href="http://www.internetifmc.com">www.internetifmc.com</a>             |
| <b>Kansas</b>               | Kansas Foundation for Medical Care          | 800-432-0407            | <a href="http://www.kfmc.org">www.kfmc.org</a>                             |
| <b>Kentucky</b>             | Health Care Excel                           | 800-300-8190            | <a href="http://www.hce.org">www.hce.org</a>                               |
| <b>Louisiana</b>            | Louisiana Health Care Review                | 800-433-4958            | <a href="http://www.lhcr.org">www.lhcr.org</a>                             |
| <b>Maine</b>                | Northeast Health Care Quality Foundation    | 800-772-0151            | <a href="http://www.nhcqf.org">www.nhcqf.org</a>                           |
| <b>Maryland</b>             | Delmarva Foundation for Medical Care        | 410-822-0697            | <a href="http://www.delmarvafoundation.org">www.delmarvafoundation.org</a> |

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| State                 | Organization Name                                       | Telephone Number | Web site Link                                                            |
|-----------------------|---------------------------------------------------------|------------------|--------------------------------------------------------------------------|
| <b>Massachusetts</b>  | MassPRO                                                 | 781-890-0011     | <a href="http://www.masspro.org">www.masspro.org</a>                     |
| <b>Michigan</b>       | Michigan Peer Review Organization                       | 248-465-7300     | <a href="http://www.mpro.org">www.mpro.org</a>                           |
| <b>Minnesota</b>      | Stratis Health                                          | 877-STRATIS      | <a href="http://www.stratishealth.org">www.stratishealth.org</a>         |
| <b>Mississippi</b>    | Mississippi Information and Quality Healthcare          | 601-957-1575     | <a href="http://www.iqh.org">www.iqh.org</a>                             |
| <b>Missouri</b>       | Primaris                                                | 800-735-6776     | <a href="http://www.primaris.org">www.primaris.org</a>                   |
| <b>Montana</b>        | Mountain-Pacific Quality Health Foundation              | 800-497-8232     | <a href="http://www.mpqhf.org">www.mpqhf.org</a>                         |
| <b>Nebraska</b>       | CIMRO of Nebraska                                       | 800-458-4262     | <a href="http://www.cimronebraska.org">www.cimronebraska.org</a>         |
| <b>Nevada</b>         | HealthInsight                                           | 702-385-9933     | <a href="http://www.healthinsight.org">www.healthinsight.org</a>         |
| <b>New Hampshire</b>  | Northeast Health Care Quality Foundation                | 800-772-0151     | <a href="http://www.nhcqf.org">www.nhcqf.org</a>                         |
| <b>New Jersey</b>     | Peer Review Organization of New Jersey                  | 732-238-5570     | <a href="http://www.pronj.org">www.pronj.org</a>                         |
| <b>New Mexico</b>     | New Mexico Medical Review Association                   | 800-663-6351     | <a href="http://www.nmmra.org">www.nmmra.org</a>                         |
| <b>North Carolina</b> | Medical Review of North Carolina                        | 800-682-2650     | <a href="http://www.mrnc.org">www.mrnc.org</a>                           |
| <b>North Dakota</b>   | North Dakota Health Care Review                         | 800-472-2902     | <a href="http://www.ndhcrci.org">www.ndhcrci.org</a>                     |
| <b>Ohio</b>           | Ohio KePRO                                              | 216-447-9604     | <a href="http://www.ohiokepro.com">www.ohiokepro.com</a>                 |
| <b>Oklahoma</b>       | Oklahoma Foundation for Medical Quality                 | 405-840-2891     | <a href="http://www.ofmq.com">www.ofmq.com</a>                           |
| <b>Oregon</b>         | Oregon Medical Professional Review Organization (OMPRO) | 503-279-0100     | <a href="http://www.ompro.org">www.ompro.org</a>                         |
| <b>Pennsylvania</b>   | Quality Insights of Pennsylvania                        | 877-346-6180     | <a href="http://www.qipa.org">www.qipa.org</a>                           |
| <b>Rhode Island</b>   | Quality Partners of Rhode Island                        | 401-528-3200     | <a href="http://www.qualitypartnersri.org">www.qualitypartnersri.org</a> |
| <b>South Carolina</b> | Carolina Medical Review                                 | 800-922-3089     | <a href="http://www.mrnc.org">www.mrnc.org</a>                           |
| <b>South Dakota</b>   | South Dakota Foundation for Medical Care                | 605-336-3505     | <a href="http://www.sdfmc.org">www.sdfmc.org</a>                         |
| <b>Tennessee</b>      | Center for Healthcare Quality                           | 901-682-0381     | <a href="http://www.qsource.org">www.qsource.org</a>                     |
| <b>Texas</b>          | TMF Health Quality Institute                            | 800-725-9216     | <a href="http://www.tmf.org">www.tmf.org</a>                             |
| <b>Utah</b>           | HealthInsight                                           | 801-892-0155     | <a href="http://www.healthinsight.org">www.healthinsight.org</a>         |

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| State         | Organization Name                          | Telephone Number | Web site Link        |
|---------------|--------------------------------------------|------------------|----------------------|
| Vermont       | Northeast Health Care Quality Foundation   | 800-772-0151     | www.nhcqf.org        |
| Virginia      | Virginia Health Quality Center             | 804-289-5320     | www.vhqc.org         |
| Washington    | Qualis Health                              | 800-949-7536     | www.qualishealth.org |
| West Virginia | West Virginia Medical Institute            | 800-642-8686     | www.wvmi.org         |
| Wisconsin     | MetaStar                                   | 800-362-2320     | www.metastar.com     |
| Wyoming       | Mountain-Pacific Quality Health Foundation | 877-810-6248     | www.mpqhf.org        |

### Getting a QIO review of your Hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge and Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for an expedited seventy-two (72)-hour review of whether you are ready to leave the Hospital.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the Hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the Hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon of the calendar day after the QIO gives you its decision.

- If the QIO agrees with you, then PLHIC will continue to cover your Hospital stay for as long as Medically Necessary.

### What If You Do Not Ask the QIO for a Review by the Deadline?

You may have to pay for your Hospital care if you stay past your discharge date.

If you do not ask the QIO by noon of the next working day after you are given written notice that you are being discharged from the Hospital, and if you stay in the Hospital after this date, you run the risk of having to pay for the Hospital care you receive on and after this date. However, you can Appeal any bills for Hospital care you received as described above.

### Another Option: Asking for an Expedited 72-Hour Review of Your Discharge

If you do not ask the QIO to do an expedited seventy-two (72)-hour review of your discharge, you can ask PLHIC for an expedited seventy-two (72)-hour review of your discharge. This is described above. If you ask PLHIC for an expedited seventy-two (72)-hour review of your discharge and you stay in the Hospital past your discharge date, you run the risk of having to pay for the Hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision PLHIC makes.

- If PLHIC decides, based on the expedited seventy-two (72)-hour review, that you need

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to stay in the Hospital, your Hospital care will be covered for as long as Medically Necessary.

- If PLHIC decides that you should not have stayed in the Hospital beyond your discharge date, then any Hospital care you received if you stayed in the Hospital after the discharge date will **not** be covered.

#### **Termination of Services in Certain Provider Settings (Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF))**

When coverage for a course of treatment ends in a SNF, HHA, or CORF, you should receive advance written notification of the termination of services that includes your Appeal rights and the date on which coverage of the service ends. This notice is called the *Notice of Medicare Non-Coverage*. You must receive the notice no later than two (2) days prior to the termination (or at the time of admission if your stay is expected to be less than two (2) days). You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the SNF, HHA or CORF — it only means that you received the notice. If you do not receive the notice when you are being told about the termination of services, ask for it immediately.

#### **Review of Termination of SNF, HHA or CORF Services by the QIO**

If you think coverage of your services in a SNF, HHA or CORF is being terminated too soon, you have the right by law to request a “fast-track” Appeal by contacting the QIO in writing or by telephone:

- If you get this notice two (2) days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get this notice and you have more than two (2) days before your coverage ends, then you must make your request **no later than noon** the day before the date that your coverage ends. The QIO will notify PLHIC that you are Appealing the termination, and

PLHIC will issue a *Detailed Explanation of Non-Coverage* to both you and the QIO.

The QIO will review your medical information, then give an opinion about whether it is medically appropriate that your services are being terminated. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that the termination of services was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you received from PLHIC. Neither Original Medicare nor PLHIC will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability. You may request a reconsideration by the QIO, but you will be liable for any services received following the date on which you receive the QIO's initial decision. **Note: Decisions made by the QIO cannot be Appealed through PLHIC.**
- If the QIO agrees with you, then PLHIC will continue to cover your services for only as long as is Medically Necessary or based on Medicare coverage limitations.

#### **Asking for an Expedited/72-Hour Review of your Termination of Services**

You may Appeal the termination of SNF, HHA or CORF services under the Expedited (72-Hour) Appeal Process described earlier in this section only if you miss the deadline for a fast-track Appeal through the QIO.

If you ask PLHIC for an expedited Appeal of your termination and you continue getting services from the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care that you receive on or after this date. However, you can Appeal any bills for SNF, HHA or CORF care you receive using the standard Appeal process described earlier in this section.

## Grievance Procedures

### Informal Complaints

PLHIC will attempt to resolve any complaint (Grievance) you might have. PLHIC encourages the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. If you have a complaint, please call Customer Service. A more formal Grievance procedure is available, if your complaint cannot be resolved in this manner.

### Formal Complaints

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you have the right to file a complaint — also called a Grievance - about problems you observe or experience, including:

- Complaints about the quality of services that you receive;
- General complaints about increases in Enrollee liability or benefit design;
- Involuntary Disenrollment situations (see Section 9);
- If you disagree with PLHIC's decision to extend the timeframe on a standard or expedited request;
- If you disagree with PLHIC's decision to extend the timeframe on a standard or expedited Appeal;
- If you disagree with PLHIC's decision to process your organization determination request for service under the standard fourteen (14)-day timeframe rather than expedited/seventy-two (72)- hour timeframe;
- If you disagree with PLHIC's decision to process your reconsideration (Appeal) request under the standard thirty (30)-day timeframe rather than the expedited/seventy-two (72)- hour timeframe.

To use the formal Grievance procedure, submit your Grievance to PLHIC Appeals and Grievances Unit.

However, complaints about a decision regarding payment or provision of Covered Services that you believe are covered by Medicare and should be arranged or paid for by PLHIC must be Appealed through the SecureHorizons Direct<sup>SM</sup> Medicare Appeals procedure (see above).

### Complaints That Do Not Relate to Quality of Medical Care Issues

PLHIC reviews complaints that do not relate to quality of medical care issues in consultation with appropriate PLHIC departments. PLHIC will write you to acknowledge your complaint and let you know how PLHIC has addressed your concern within thirty (30) days of receiving your written Grievance. If your Grievance is related to PLHIC's decision to invoke an extension on your request for an organization determination or reconsideration, or PLHIC's decision to process your expedited request as a standard request, PLHIC will acknowledge your Grievance within twenty-four (24) hours of receipt and notify you in writing of PLHIC's conclusion. In some instances, PLHIC will need additional time to address your concern. If additional time is needed, PLHIC will keep you informed regarding the status of your Grievance.

### Complaints Involving Quality of Medical Care Issues - QIO Quality of Care Complaint Process

If you are concerned about the quality of care you have received, you may file a complaint with the QIO in your local area. For the name and phone number of the QIO for your area, please refer to the QIO Chart on page 35, contact Customer Service or go to [www.medqic.org](http://www.medqic.org) on the Internet. You can also send your complaint to PLHIC and it will be forwarded to your QIO.

### Binding Arbitration

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were

unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between Enrollee (including any heirs or assigns) and PLHIC or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare"), shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Enrollee and PacifiCare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Enrollee lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of the State including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and State law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PacifiCare may assume all or part of the Enrollee's share of the fees and expenses of JAMS and the arbitrator, provided the Enrollee submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

**BY ENROLLING IN SECUREHORIZONS DIRECT<sup>SM</sup> OFFERED BY PLHIC, BOTH ENROLLEE (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE AGREE TO WAIVE THE CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS EVIDENCE OF COVERAGE.**

Nothing within this Arbitration provision alters a Medicare beneficiary's right to use the Medicare Appeals process. Binding arbitration provision will be used to resolve any matters that are not fully resolved through the Medicare Appeals process or are not subject to the Medicare Appeals process.

## **Section 9**

### **Disenrollment From SecureHorizons Direct<sup>SM</sup>**

#### **Voluntary Disenrollment**

You may choose to end your enrollment in SecureHorizons Direct<sup>SM</sup> for any reason. However, as we explain in this section, **starting in 2006 there are limits to when you may Disenroll from SecureHorizons Direct<sup>SM</sup>, how often you can make changes, and what type of plan you can join after you Disenroll.**

If you wish to Disenroll:

- Be sure that the type of change you want to make and when you want to make it fit within the new rules (see below for details or call Customer Service).

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

- You or your authorized representative may request Disenrollment directly from PLHIC; you must send a written, signed and dated letter to PLHIC. If you have any questions about the letter please contact Customer Service.
- Call the national Medicare help line at 1-800-MEDICARE (1-800-633-4227), TTY/TDD access line 1-877-486-2048, 24 hours a day, seven days a week to Disenroll via the phone.

Starting in 2006, there are limits to when and how often you can change the way you get Medicare and what choices you can make when you make the change.

1. From **January 1, 2006 until June 30, 2006**, anyone with Medicare can make one change in the way they get Medicare (e.g., Disenroll from SecureHorizons Direct<sup>SM</sup>)

During this time you are limited in the type of plan you may join. If you have Medicare prescription drug coverage when making your change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that offers the Medicare Part D (prescription drug), or you will have to go to Original Medicare and join a stand-alone prescription drug plan. If you do not have Medicare prescription drug coverage when making this change, you will only be able to join a Medicare Advantage Plan or Private Fee-For-Service plan that does not offer the Medicare Part D (prescription drug), or go to Original Medicare.

2. Generally, **after June 30, 2006** you cannot make any other changes during the year unless you meet special exceptions, such as moving out of the Service Area or if you have Medicaid/Medi-Cal coverage. Contact Customer Service for information.
3. From **November 15, 2006 through December 31, 2006**, you may Disenroll from SecureHorizons Direct<sup>SM</sup> and choose a different health plan or return to Original Medicare for 2007. (For more information on Enrollment rules, see Section 2.)

### The Effective Date of Your Disenrollment

In most cases, your Disenrollment date will be the first day of the month *after* the month your

request to Disenroll is received. For example, if we receive your request to Disenroll during the month of February, your Disenrollment date will be March 1.

Until your enrollment ends, you are still an Enrollee and you must keep following the rules of SecureHorizons Direct<sup>SM</sup>. PLHIC will send you a letter that informs you when your Disenrollment is effective. Once your Disenrollment is effective, you can begin using your red, white and blue Medicare card to obtain services under Medicare unless you have joined another Medicare Advantage Plan. (Note: You can call Social Security at 1-800-772-1213 if you need a new Medicare card.)

### Moves or an Extended Absence from the Service Area

If you are permanently moving out of the Service Area or plan an extended absence of more than six (6) months, it is important to notify PLHIC of the move or extended absence before you leave the Service Area. If you move permanently out of the Service Area, or if you are away from the Service Area for more than six (6) consecutive months, you will need to Disenroll from SecureHorizons Direct<sup>SM</sup>.

Failure to notify PLHIC of a permanent move or an extended absence may result in your involuntary Disenrollment from SecureHorizons Direct<sup>SM</sup> since PLHIC is required to Disenroll you if you have moved out of the Service Area for more than six (6) months.

PLHIC currently offers Medicare Advantage Private Fee-For-Service Plans in counties within the following States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

and Wyoming. If you are moving outside of your Service Area, you may be eligible to enroll in a SecureHorizons Direct<sup>SM</sup> plan in your new location. Health Plan Premiums, Copayments, Coinsurance and Covered Services will vary from one area to another. Please contact Customer Service for information and assistance in completing any necessary paperwork.

For information on other plans available in your area, you can call 1-800-MEDICARE (1-800-633-4227) or the hearing impaired 1-877-486-2048, 24 hours a day, seven days a week or visit the CMS Web site at: [www.Medicare.gov](http://www.Medicare.gov) on the Internet.

### **What Happens if PLHIC leaves the Medicare Program or Leaves the Service Area Where You Live?**

If PLHIC leaves the Medicare program or discontinues offering SecureHorizons Direct<sup>SM</sup> in your Service Area, we will notify you in writing. **If either of these situations occur, you will be allowed to change the way you receive Medicare coverage.** Your choices will always include Original Medicare, and they may also include joining another Medicare Advantage plan or a Private Fee-for-Service plan if such plans are available in your area and are accepting new Enrollees.

PLHIC has a contract with CMS. This contract renews each year. At the end of each year, the contract is reviewed and either PLHIC or CMS can decide to end it. It is also possible for PLHIC's contract to end at some other time. If the contract is going to end, PLHIC will generally notify you at least ninety (90) days in advance. Your advance notice may be as little as thirty (30) days or even fewer days if CMS ends PLHIC's contract in the middle of the year.

Until PLHIC notifies you in writing that you must Disenroll from SecureHorizons Direct<sup>SM</sup> and indicates the date that your enrollment will end, you will continue as an Enrollee of SecureHorizons Direct<sup>SM</sup>. All Covered Services and rules described in this document will continue until your enrollment ends.

Once PLHIC has notified you in writing that PLHIC is leaving the Medicare program or leaving

the area where you live, you may switch to another way of getting your Medicare benefits at anytime. If you decide to switch from SecureHorizons Direct<sup>SM</sup> to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called "guaranteed issue rights." For information about how and when to buy a Medigap policy if you need one, call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 24 hours a day, seven days a week or the State Health Insurance Assistance Program (SHIP).

### **Coverage That Ends During an Inpatient Hospital Stay**

If your coverage under SecureHorizons Direct<sup>SM</sup> ends while you are an inpatient in a Hospital (or Hospital unit), PLHIC may be responsible for the inpatient services until the date of your discharge. PLHIC Customer Service Representatives can advise you if PLHIC is responsible for your inpatient services. In this case, PLHIC is not responsible for medical services, other than inpatient Hospital services, furnished on or after the effective date of your Disenrollment.

### **Involuntary Disenrollment**

PLHIC must Disenroll you from SecureHorizons Direct<sup>SM</sup> under the conditions listed below. You will not be Disenrolled due to your health status.

- If you move out of the Service Area or live outside the Service Area for more than six (6) months at a time and do not voluntarily Disenroll.
- If you do **not** stay continuously enrolled in both Medicare Part A and Medicare Part B.

You may be Disenrolled from SecureHorizons Direct<sup>SM</sup> under the following conditions:

- If you provide information on your Individual Election Form that is false or deliberately misleading, and it affects whether or not you can enroll in SecureHorizons Direct<sup>SM</sup>.
- If you behave in a way that is unruly, uncooperative, disruptive or abusive, and this behavior seriously affects PLHIC's ability to arrange Covered Services for you or for

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others who are SecureHorizons Direct<sup>SM</sup> Enrollees. Before PLHIC can Disenroll you for this reason, PLHIC **must obtain permission** from the Centers for Medicare & Medicaid Services (CMS), the government agency that administers Medicare.

- If you allow someone else to use your SecureHorizons Direct<sup>SM</sup> ID card to obtain Covered Services. Before PLHIC will Disenroll you for this reason, PLHIC must refer your case to the Inspector General, which may result in criminal prosecution.
- If you do not pay any applicable Health Plan Premiums. PLHIC may Disenroll after making a reasonable effort to collect the Health Plan Premium, providing you with written notice and notifying you of the Grievance procedures. Should you decide later to re-enroll in a Secure Horizons plan, you must pay any outstanding Health Plan Premiums due from your previous enrollment.

#### **You Have the Right to File a Complaint if PLHIC Asks You to Leave SecureHorizons Direct<sup>SM</sup>**

If PLHIC does ask you to leave SecureHorizons Direct<sup>SM</sup> PLHIC will inform you of the reasons in writing and explain how you can file a Grievance if you choose to.

**Until PLHIC notifies you in writing that you have been Disenrolled, you will continue to be a SecureHorizons Direct<sup>SM</sup> Enrollee and until your enrollment officially ends, you must keep following the rules of SecureHorizons Direct<sup>SM</sup> or you may have to pay for services not defined as Covered Services.**

#### **PLHIC Cannot Ask You to Leave Due to Your Health**

You can only be asked to leave SecureHorizons Direct<sup>SM</sup> under certain special conditions that are described above. These conditions do not include asking you to leave due to your health. No Enrollee of any Medicare health plan can be asked to leave the plan for any health-related reasons.

If you ever feel you are being encouraged or asked to Disenroll from SecureHorizons Direct<sup>SM</sup> due to your health, you should call the national Medicare

help line at 1-800-MEDICARE or 1-800-633-4227, or TTY/TDD access line 1-877-486-2048, 24 hours a day, seven days a week.

## **Section 10**

### **Coordinating Other Benefits You May Have**

If you have other health insurance coverage in addition to SecureHorizons Direct<sup>SM</sup> it is important to use this other coverage **in combination with** your SecureHorizons Direct<sup>SM</sup> coverage to help pay for the cost of the Covered Services that you receive. The use of other health insurance available to you with your SecureHorizons Direct<sup>SM</sup> coverage is called "coordination of benefits" because it involves coordinating all of your health care coverage.

Please keep PLHIC up-to-date on any other health insurance coverage you have such as the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under Workers' Compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid/Medi-Cal.
- Coverage through the "TriCare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

#### **Who Pays First?**

As an Enrollee, you are always entitled to receive Covered Services through SecureHorizons Direct<sup>SM</sup>. Medicare law, however, gives PLHIC or its designee the right to recover payments from certain "third party" insurance companies or from you if you were paid by a "third

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party.” Because of this, PLHIC may ask you for information about other insurance that you may have. If you have other insurance, you can help PLHIC obtain payment from the other insurer by promptly providing the requested information.

If any no-fault or any liability insurance is available to you, benefits under that plan must be applied to the costs of health care covered by that plan. Where PLHIC has provided benefits, and a judgment or settlement is made with a no-fault or liability insurer, you must reimburse PLHIC or its designee (entity or person selected for this purpose) to the extent of your medical expenses. However, PLHIC's reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' Compensation from treatment of a work-related illness or injury should also be applied to covered health care costs.

If you do not have end-stage renal disease (ESRD), and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that plan prior to using your SecureHorizons Direct<sup>SM</sup> benefits. Similarly, if you do not have ESRD, but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) through a spouse's employer group coverage, you must use the benefits under that plan prior to using your SecureHorizons Direct<sup>SM</sup> benefits. In such cases you will only receive benefits not covered by your employer group plan through PLHIC's contract with Medicare (and PLHIC will only be paid an amount by Medicare to cover such “wrap around” benefits). A special rule applies if you have or develop ESRD.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as

described above, Medicare continues to be the primary payer.

For additional information, Medicare has a booklet called “Medicare and Other Health Benefits: Your Guide to Who Pays First.” You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, seven days a week or by visiting the [www.medicare.gov](http://www.medicare.gov) Web site.

## Section 11

### Advance Directives

#### Making Your Health Care Wishes Known

PLHIC is required by law to inform you of your right to make health care decisions and to execute an Advance Directive. An Advance Directive is a formal document, written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, Providers will honor your wishes. If you become so sick that you cannot speak for yourself, this directive will guide your Providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of Advance Directives you can choose from, depending on State law.

Most States recognize:

- DPAHC (Durable Power of Attorney for Health Care)/Medical Durable Power of Attorney
- Health Care Directive
- Living Wills
- Natural Death Act Declarations
- Cardiopulmonary Resuscitation (CPR) Directive
- Do Not Resuscitate (DNR) Orders

You are not required to initiate an Advance Directive, and you will not be denied care if you do not have an Advance Directive. It is necessary for you to provide copies of your completed directive to all of the following:

- your Provider

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- your agent or representative (if you have one)
- your family

If you decide that you want to have an Advance Directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, the Internet and from some office supply stores.

Be sure to keep a copy with you and take a copy to the Hospital when you are Hospitalized for medical care. If you have questions regarding Advance Directives or end of life treatment decisions, please contact State Health Insurance Assistance Program (SHIP).

## ***Section 12***

### **General Provisions**

#### **Governing Law**

The Evidence of Coverage is subject to the laws of the United States of America, including Title XVIII of the Social Security Act and the regulations promulgated thereunder by CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State may apply. Any provisions required to be in the Evidence of Coverage by any of the above acts and regulations shall bind PLHIC and you, whether or not expressly provided in this document.

#### **Your Financial Liability as a SecureHorizons Direct<sup>SM</sup> Enrollee**

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you will also be financially responsible for the Copayments, Coinsurance amounts, and Part B Excess Charges, if applicable, up to the Out-of-Pocket Maximum, that is listed in the Schedule of Benefits. Expenses not covered by SecureHorizons Direct<sup>SM</sup> do NOT count toward your annual Out-of-Pocket Maximum.

#### **Medicare Prescription Drug Coverage**

Beginning January 1, 2006, new Medicare prescription drug coverage (Medicare Part D) will be available to all people with Medicare.

SecureHorizons Direct<sup>SM</sup> **does not** include prescription drug coverage. If you are interested in learning more about the Prescription Drug Plans offered by Prescription Solutions<sup>®</sup> from PacifiCare,<sup>®</sup> please call 1-800-776-8876 (hearing impaired 1-800-387-1074), 6 a.m. to 7 p.m. PST, Monday through Friday, 8 a.m. to 12 p.m. PST, Saturday. You can also visit [www.PartDandMe.com](http://www.PartDandMe.com) on the Internet for more information.

#### **The Medicare Drug Discount Card**

The Medicare-approved drug discount cards were offered as a transition step to help people with Medicare save money on prescription drug costs until Medicare Part D became available. You can use your drug discount card along with the \$600 Transitional Assistance credit that was provided in 2004/2005 to those who qualified for limited income and resources assistance until May 15, 2006 at which time it will be discontinued. If you decide to enroll in a Part D plan before May 15, you will no longer use your Medicare-approved drug discount card since your Prescription Drug Plan (like one of the plans offered by Prescription Solutions<sup>®</sup> from PacifiCare<sup>®</sup>) will provide your coverage for prescription drugs.

#### **You must pay the full cost of services that are not defined as Covered Services.**

You are responsible to pay for care and services that are not defined as Covered Services under the SecureHorizons Direct<sup>SM</sup> plans.

#### **Enrollee Non-Liability**

In the event PLHIC fails to reimburse a Deemed Provider's charges for Covered Services occurring when you were actively enrolled in SecureHorizons Direct<sup>SM</sup> you will not be liable for any sums owed by PLHIC.

#### **Third Party Liability**

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, PLHIC shall furnish all Covered Services. However, you agree to fully reimburse PLHIC or its designee for the cost of all such services and benefits provided, immediately

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upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of PLHIC or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of PLHIC, wherein such release or settlement will extinguish or act as a bar to PLHIC's right of reimbursement.

### **Reimbursement of Third Party Medical Expenses**

If you receive medical services under your SecureHorizons Direct<sup>SM</sup> coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse PLHIC, or its designee, to the extent permitted under State and federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

You must obtain the written consent of PLHIC or its nominee (entity or person authorized to give consent) prior to settling any claim, or releasing any third party from liability, if such settlement or release would limit the reimbursement rights of PLHIC or its nominee.

You are required to cooperate in protecting the interests of PLHIC or its nominee by providing all liens, assignments or other documents necessary to secure reimbursement to PLHIC or its nominee. Failure to cooperate with PLHIC or its nominee in this regard could result in termination of your SecureHorizons Direct<sup>SM</sup> enrollment.

Should you settle your claim against a third party and compromise the reimbursement rights of PLHIC or its nominee without PLHIC's written consent, or otherwise fail to cooperate in protecting the reimbursement rights of PLHIC or its nominee, PLHIC may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

### **Non-Duplication of Benefits With Automobile, Accident or Liability Coverage**

If you are receiving benefits as a result of other automobile, accident or liability coverage, PLHIC will not duplicate those benefits.

It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected, and to notify PLHIC of such coverage when available.

If PLHIC happens to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, PLHIC may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier or your health care Provider to the extent permitted under State and/or federal law.

**PLHIC will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.**

You are required to cooperate with PLHIC in obtaining payment from your automobile, accident or liability coverage carrier, and your failure to do so may result in termination of your SecureHorizons Direct<sup>SM</sup> enrollment.

### **Acts Beyond the Control of PLHIC**

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within PLHIC's control), or any other emergency or similar event not within the control of PLHIC, Providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage, then PLHIC shall attempt to arrange for Covered Services insofar as practical and according to PLHIC's best judgment. Neither PLHIC nor any Provider shall have any liability or obligation for delay or failure to provide or arrange for Covered Services if such delay is the result of any of the circumstances described above.

### Physician-Patient Relationship

PLHIC does not prohibit or otherwise restrict a Physician, acting within the lawful scope of practice, from advising or advocating on your behalf about:

1. Your health status, medical care or treatment options
2. The risk, benefits and consequences of treatment or non-treatment
3. The opportunity for you to refuse treatment and to express preferences about future treatment decisions.

### Notices

Any notice required to be given under this Evidence of Coverage shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other address as the parties may designate:

If to PLHIC:

SecureHorizons Direct<sup>SM</sup>  
Attn: Customer Service  
P.O. 4169  
Scranton, PA 18505

If to you, to your last address known to PLHIC.

### Technology Assessment

PLHIC regularly reviews new procedures, devices and drugs to determine whether or not they are safe and efficacious for our Enrollees. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other Terms and Conditions of the plan, including Medical Necessity and any applicable Enrollee Copayments, Coinsurance and Out-of-Pocket Maximums.

In determining whether to cover a service, PLHIC uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new

application of an existing technology for an individual Enrollee, a PacifiCare

Medical Director makes a Medical Necessity determination based on individual Enrollee medical documentation, review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

### Important Information About Organ and Tissue Donations

Transplantation has helped thousands of people suffering from organ failure, or in need of corneas, skin, bone or other tissue. The need for donated organs and tissues continues to outpace the supply. At any given time, nearly 50,000 Americans may be waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others.

### Almost Anyone Can Be a Donor

There is no age limit and the number of donors age 50 or older has increased. If you have questions or concerns about organ donation, speak with your family, doctor or clergy member. There are many resources that can provide the information you need to make a responsible decision.

### Be Sure to Share Your Decision

Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a family member gives consent at the time of your death, even if you have signed your driver's license or a donor card. A simple family conversation may help to prevent confusion or uncertainty about your wishes. It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

## How to Learn More

- To obtain your donor card and information on organ and tissue donation, call 1-800-355-SHARE or 1-800-633-6562.
- Request Donor Information from your local Department of Motor Vehicles (DMV).
- On the Internet, contact:
  - All About Transplantation and Donation at [www.transweb.org](http://www.transweb.org).
  - Department of Health and Human Services at <http://www.organdonor.gov>.
- Sign the donor card in your family's presence.
- Have your family sign as witnesses and pledge to carry out your wishes.
- Keep the card with you at all times where it can be easily found.
- Keep in mind that even if you've signed a donor card, you must inform your family so they can act on your wishes.

## Information Upon Request

As a SecureHorizons Direct<sup>SM</sup> Enrollee, you have the right to request information on the following:

- General coverage and comparative plan information
- Quality Improvement Programs
- Statistical data on Grievances and Appeals
- The financial condition of PLHIC/PacificCare

## Corporate Address

You may write to PLHIC's Corporate Offices at:  
SecureHorizons Direct<sup>SM</sup>  
P.O. Box 4169  
Scranton, PA 18505

## Section 13

### SecureHorizons Direct<sup>SM</sup> Service Area

The SecureHorizons Direct<sup>SM</sup> Service Area includes the following states and counties:

#### Plan 1

**Alabama:** Lowndes, Russell

**Alaska:** Kodiak Island, Nome, Upper Yukon

**Arizona:** Graham, Pima, Santa Cruz

**Arkansas:** Benton, Carroll, Franklin, Newton, Scott, Searcy, Sebastian

**California:** Alpine, Fresno, Madera, Santa Barbara, Solano, Tulare, Yolo

**Colorado:** Alamosa, Gilpin, Las Animas, Park, Saguache

**Georgia:** Chattahoochee, Clay, Columbia, Coweta, Early, Haralson, Harris, Irwin, Jones, Lanier, Marion, Meriwether, Muscogee, Pike, Quitman, Richmond, Treutlen, Washington

**Hawaii:** Kauai, Maui

**Idaho:** Ada, Boise, Canyon, Cassia, Franklin, Jerome, Minidoka, Owyhee, Power

**Illinois:** Boone, Edgar, Marshall, Ogle, Peoria, Schuyler, Stark, Tazewell, Woodford

**Indiana:** Adams, Allen, Brown, Dearborn, Franklin, Fulton, Kosciusko, Putnam, St. Joseph, Wabash, Washington, Whitley

**Iowa:** Appanoose, Benton, Boone, Buena Vista, Cedar, Cherokee, Clarke, Crawford, Dallas, Decatur, Delaware, Fayette, Floyd, Franklin, Greene, Grundy, Hamilton, Hancock, Jasper, Johnson, Jones, Kossuth, Linn, Louisa, Lucas, Madison, Mitchell, Muscatine, Palo Alto, Polk, Scott, Sioux, Story, Tama, Warren, Wayne, Worth

**Kansas:** Harvey, Morris, Saline

**Kentucky:** Bath, Clark, Fayette, Jessamine, Madison, Menifee, Montgomery, Powell, Scott, Woodford

**Louisiana:** Iberville, St. James

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**Maine:** Cumberland, Sagadahoc, York

**Michigan:** Barry, Dickinson, Kent, Newaygo, Ottawa

**Minnesota:** Big Stone, Blue Earth, Brown, Chippewa, Douglas, Houston, Jackson, Kandiyohi, Kittson, Martin, Nobles, Redwood, Rock, Steele, Todd, Wabasha, Watonwan, Winona

**Mississippi:** Lafayette, Oktibbeha

**Missouri:** Christian, Greene, Oregon, Polk, Saline, Texas, Webster

**Montana:** Broadwater, Carter, Custer, Dawson, Fergus, Garfield, Judith Basin, Lincoln, McCone, Meagher, Petroleum, Powder River, Prairie, Sheridan, Treasure, Wibaux

**Nebraska:** Banner, Blaine, Boone, Box Butte, Buffalo, Butler, Cheyenne, Dawes, Dixon, Furnas, Gosper, Greeley, Hooker, Jefferson, Kearney, Kimball, Loup, Phelps, Scotts Bluff, Sheridan, Sioux, Wayne, Wheeler

**Nevada:** Esmeralda

**New Mexico:** Catron, Colfax, Grant, Hidalgo, Luna, Mora, Rio Arriba, San Miguel, Santa Fe, Taos

**North Carolina:** Alamance, Alexander, Ashe, Buncombe, Burke, Caldwell, Caswell, Catawba, Chatham, Chowan, Clay, Cumberland, Currituck, Davidson, Davie, Durham, Forsyth, Franklin, Graham, Guilford, Haywood, Henderson, Macon, Madison, Mitchell, Orange, Person, Randolph, Rockingham, Stokes, Tyrrell, Vance, Warren, Yadkin, Yancey

**North Dakota:** Barnes, Billings, Eddy, Golden Valley, Pembina, Ramsey, Renville, Richland, Stutsman, Traill, Williams

**Ohio:** Greene, Holmes, Licking, Miami

**Oregon:** Baker, Klamath, Sherman, Union

**Pennsylvania:** Bradford, Clinton, Columbia, Lancaster, Lebanon, Lycoming, Montour, Sullivan, York

**Rhode Island:** Bristol

**South Carolina:** Calhoun, Edgefield, Laurens

**South Dakota:** Beadle, Bennett, Brookings,

Butte, Campbell, Clark, Codrington, Grant, Hamlin, Hughes, Lake, Lawrence, Meade, Roberts, Sanborn, Stanley

**Tennessee:** Bledsoe, Cannon, Carter, Marion, Sevier, Sullivan, Union

**Texas:** Bee, Chambers, Concho, Glasscock, Hansford, Jim Wells, Kinney, Loving, Sterling

**Utah:** Box Elder, Daggett, Davis, Duchesne, Garfield, Grand, Morgan, Piute, Rich, Salt Lake, Sevier, Summit, Weber

**Vermont:** Orleans

**Virginia:** Amelia, Charlotte, Clarke, Craig, Culpeper, Cumberland, Emporia, Floyd, Galax City, Goochland, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henry, Highland, Isle of Wight, Lunenburg, Middlesex, Norfolk City, Pittsylvania, Poquoson City, Portsmouth City, Prince Edward, Roanoke City, Rockbridge, Rockingham, Salem, Scott, Suffolk City, Surry, Sussex, Virginia Beach City, Warren, Washington, Wythe

**Washington:** Kitsap, Skamania

**West Virginia:** Clay, Grant, Pendleton, Roane, Upshur, Wayne

**Wisconsin:** Barron, Buffalo, Dodge, Fond Du Lac, Green, Green Lake, Jackson, La Crosse, Marinette, Menominee, Monroe, Ozaukee, Richland, Rusk, Shawano, Sheboygan, Vernon, Washington, Waupaca

**Wyoming:** Goshen, Johnson, Sheridan

## Plan 2

**Alabama:** Bibb, Bullock, Montgomery, Shelby

**Alaska:** Barrow-North Slope

**Arizona:** Cochise, Yavapai

**Arkansas:** Crawford

**California:** Placer, Sacramento

**Colorado:** Chaffee, Dolores, Elbert, Fremont, Gunnison, Hinsdale, Kiowa, Lincoln, Mineral, Routt

**Florida:** Flagler, Jefferson

**Georgia:** Burke, Clarke, Dawson, Dacatur, Elbert, Evans, Fayette, Grady, Lamar, Morgan, Tift, Webster

**Idaho:** Bear Lake, Clark, Gem

**Illinois:** Champaign, Crawford, Mercer, Winnebago

**Indiana:** Gibson, Jackson, LaGrange, Marshall, Noble, Orange, Posey

**Iowa:** Clinton, Davis, Ida, Jackson, Page, Poweshiek, Wapello

**Kansas:** Decatur, Dickinson, Ottawa, Smith

**Kentucky:** Elliott, Marion, Webster

**Louisiana:** Ascension, Assumption, Plaquemines, Pointe Coupee, St. Mary, West Baton Rouge

**Maine:** Kennebec

**Maryland:** Washington

**Michigan:** Cass, Lenawee

**Minnesota:** Carlton, Clearwater, Faribault, Freeborn, Grant, Lincoln, Morrison, Otter Tail, Pennington, Roseau, Sherburne, Waseca, Wilkin

**Mississippi:** Benton, Marshall, Tunica

**Missouri:** Dallas, Douglas, Franklin, Howell, Livingston

**Montana:** Jefferson, Lewis and Clark, Richland, Stillwater, Sweet Grass

**Nebraska:** Fillmore, Franklin, Gage, Garfield, Hayes, Hitchcock, Keya Paha, Knox, Madison, Morrill, Rock, Sherman, Stanton

**Nevada:** Humboldt, Lander

**New Mexico:** Harding, Lincoln, Sierra, Socorro

**North Carolina:** Beaufort, Granville, Hoke, Hyde, Rowan

**North Dakota:** Mountrail, Sioux, Ward

**Ohio:** Ashland, Brown, Carroll, Champaign, Clark, Delaware, Geauga, Marion, Morgan, Muskingum, Stark, Warren

**Oklahoma:** Washington

**Oregon:** Benton, Crook, Malheur, Umatilla, Wheeler

**Pennsylvania:** Centre, Cumberland, Erie, Franklin, Snyder, Tioga, Union, Wyoming

**South Carolina:** Allendale, Anderson, Pickens, Saluda, Spartanburg

**South Dakota:** Aurora, Brule, Corson, Custer, Davison, Hand, Hyde, Kingsbury, Mellette, Miner, Sully, Todd, Tripp, Walworth

**Tennessee:** Anderson, Blount, Hawkins, Knox, Loudon, Sequatchie, Unicoi, Warren

**Texas:** Aransas, Brewster, Brooks, Carson, Dimmit, Duval, Frio, Hartley, Haskell, Hudspeth, Jack, Kenedy, La Salle, Lipscomb, Maverick, Nueces, Rains, Roberts, Shackelford, Throckmorton

**Utah:** Cache, Emery, Iron, Millard, San Juan, Tooele, Wayne

**Vermont:** Caledonia

**Virginia:** Bedford, Brunswick, Buena Vista City, Campbell, Carroll, Chesterfield, Danville City, Franklin, Franklin City, Giles, Grayson, King and Queen, King William, Lancaster, Louisa, Madison, Manassas Park City, Martinsville City, Mecklenburg, New Kent, Northhampton, Northumberland, Nottoway, Page, Park City, Powhatan, Prince George, Prince William, Richmond, Shenandoah, Smyth, Southampton

**Washington:** Island, Klickitat, Snohomish, Spokane, Walla Walla

**West Virginia:** Berkeley, Braxton, Cabell, Doddridge, Hardy, Jefferson, Kanawha, Lincoln

**Wisconsin:** Ashland, Bayfield, Dane, Douglas, Iron, Marquette, Racine, Sawyer, St. Croix, Washburn

**Wyoming:** Park

### Plan 3

**Alabama:** Elmore, Henry, Madison

**Alaska:** Valdez-Cordova

**Arkansas:** Boone, Logan, Marion

**California:** Del Norte, San Francisco, San Joaquin

**Colorado:** Archuleta, Douglas, El Paso, Mesa, Otero, Rio Grande, San Juan, San Miguel, Weld

**Florida:** Franklin

**Georgia:** Barrow, Bartow, Ben Hill, Berrien, Candler, Catoosa, Crisp, Dooly, Douglas, Echols, Habersham, Hancock, Jackson, Jasper, Jenkins, Madison, Oconee, Peach, Rockdale, Stephens, Sumter, Talbot, Taylor, Troup, Union, Walton, Wilkes

**Hawaii:** Kalawao

**Idaho:** Bingham, Caribou, Lincoln, Twin Falls

**Illinois:** Carroll, Cass, Clark, Clinton, Coles, De Kalb, Douglas, Edwards, Hancock, Henry, Jasper, Johnson, McLean, Menard, Monroe, Moultrie, Piatt, Stephenson, Union

**Indiana:** Elkhart, Harrison, Madison, Monroe, Morgan, Newton

**Iowa:** Adair, Audubon, Butler, Calhoun, Chickasaw, Clayton, Emmet, Hardin, Harrison, Humboldt, Lee, Lyon, Mills, Monroe, Plymouth, Pottawattamie, Ringgold, Taylor, Van Buren, Webster, Woodbury

**Kansas:** Butler, Cloud, Cowley, Franklin, Mitchell, Republic

**Kentucky:** Campbell, Kenton, Oldham, Shelby

**Louisiana:** Lafourche, Madison

**Maine:** Aroostook

**Michigan:** Allegan, Gogebic, Gratiot, Ionia, Lapeer, Menominee, Ontonagon, Otsego

**Minnesota:** Cottonwood, Le Sueur, Lyon, Nicollet, Red Lake, Swift, Traverse, Washington

**Mississippi:** Calhoun, Issaquena, Lowndes, Noxubec, Quitman

**Missouri:** Caldwell, Cass, Clark, Crawford, Dade, Laclede, Ozark, Ralls, Scotland, Shannon, Vernon, Wayne

**Montana:** Beaverhead, Blaine, Flathead, Granite, Toole

**Nebraska:** Cedar, Clay, Cuming, Dakota, Dawson, Johnson, McPherson, Platte, Saunders, Seward, Washington

**New Hampshire:** Hillsboro, Strafford

**New Mexico:** Dona Ana, Guadalupe, McKinley, Otero, Quay

**North Carolina:** Bertie, Cherokee, Jackson, Moore, Northampton, Pender, Perquimans, Polk, Union, Wake

**North Dakota:** Burleigh, Cass, Cavalier, Kidder, Logan, McKenzie, McLean, Mercer

**Ohio:** Columbiana, Fulton, Hancock, Montgomery, Shelby, Union

**Oklahoma:** Nowata, Sequoyah

**Oregon:** Grant, Harney, Jefferson, Lake, Lincoln, Wasco

**Pennsylvania:** Adams, Berks, Bradford, Carbon, Dauphin, Juniata, Lackawanna, Lehigh, Northumberland, Susquehanna, Warren

**South Carolina:** Cherokee, Fairfield, Greenville, Greenwood, Newberry, Richland

**South Dakota:** Clay, Lincoln, Yankton

**Tennessee:** Decatur, Hardin, McMinn

**Texas:** Bexar, Collingsworth, Crockett, Hardin, Howard, Irion, Jefferson, Jim Hogg, Lamar, Live Oak, Lynn, Medina, Menard, Morris, Motley, Presidio, San Patricio, Terrell, Val Verde, Zavala

**Virginia:** Appomattox, Augusta, Bland, Caroline, Charles City, Greene, Henrico, Lynchburg City, Manassas City, Montgomery, Richmond City, Staunton City, Waynesboro City

**Washington:** Clallam, Columbia, King, Kittitas, Pierce, San Juan, Thurston, Wahkiakum, Whatcom, Yakima

**West Virginia:** Tucker

**Wisconsin:** Burnett, Eau Claire, Florence, Forest, Kenosha, Langlade, Manitowoc, Portage, Taylor, Waukesha, Waushara

**Plan 4**

**Alabama:** Barbour, Chambers, Fayette, Lee, Perry, Wilcox

**Alaska:** Kenai-Cook Inlet, Matanuska-Susitna, Skagway-Hoonah-Angoon, Yakutat

**Arizona:** Apache, Greenlee, Maricopa, Mohave, Pinal

**Arkansas:** Bradley, Faulkner, Fulton, Johnson, Lee, Lincoln, Lonoke, Monroe, Ouachita, Pope, Van Buren, Woodruff

**California:** Napa, Santa Clara, Santa Cruz, Sonoma

**Colorado:** Bent, Conejos, Costilla, Custer, Huerfano, Jefferson, Larimer, Logan, Phillips, Pueblo, Teller

**Florida:** Baker, Escambia, Gadsden, Marion, Santa Rosa, Volusia

**Georgia:** Baldwin, Banks, Bibb, Bryan, Butts, Camden, Carroll, Chatham, Chattooga, Clayton, Colquitt, Crawford, Dade, Effingham, Fannin, Franklin, Fulton, Glascock, Greene, Gwinnett, Hall, Heard, Henry, Houston, Jefferson, Laurens, Liberty, Lincoln, Lumpkin, Macon, Miller, Mitchell, Murray, Newton, Paulding, Pickens, Spalding, Stewart, Taliaferro, Tattnall, Thomas, Towns, Turner, Twiggs, Upson, Walker, Whitfield, Wilcox, Wilkinson

**Idaho:** Bannock, Blaine, Boundary, Custer, Latah, Lewis, Madison, Payette, Washington

**Illinois:** Adams, Cumberland, Ford, Hardin, Kendall, Livingston, Macoupin, Madison, Morgan, Richland, Saline, Sangamon, Vermilion, Whiteside, Williamson

**Indiana:** Bartholomew, Boone, Cass, Decatur, Dubois, Fayette, Grant, Hamilton, Hancock, Hendricks, Jay, Johnson, Ohio, Pulaski, Shelby, Union, Vanderburgh, Warrick

**Iowa:** Bremer, Sac

**Kansas:** Allen, Bourbon, Brown, Clay, Geary, Gray, Jefferson, Kearny, McPherson, Miami, Montgomery, Norton, Osage, Osborne, Pratt, Rawlins, Riley, Sedgwick, Sumner, Wabaunsee, Washington

**Kentucky:** Boone, Harrison, Lincoln, Mercer, Morgan, Rowan, Washington, Wayne

**Louisiana:** Allen, Calcasieu, Cameron, East Baton Rouge, East Feliciana, St. John Baptist, Terrebonne, Washington

**Maine:** Androscoggin, Knox, Penobscot, Piscataquis, Somerset, Waldo, Washington

**Massachusetts:** Dukes, Franklin

**Michigan:** Baraga, Cheboygan, Clinton, Eaton, Emmet, Houghton, Kalamazoo, Marquette, Mecosta, Midland, Muskegon, Van Buren

**Minnesota:** Becker, Clay, Fillmore, Meeker, Pope, Rice, Stearns, Wadena

**Mississippi:** Attala, Chickasaw, Choctaw, Claiborne, Clay, Copiah, George, Jackson, Madison, Montgomery, Panola, Pontotoc, Scott, Tate, Wilkinson, Yazoo

**Missouri:** Adair, Audrain, Barry, Benton, Bollinger, Boone, Carroll, Cedar, Clinton, Cooper, Gasconade, Hickory, Knox, Lafayette, Lawrence, Madison, Miller, Osage, Pemiscot, Pettis, Putnam, Randolph, Schuyler, Sullivan, Warren, Washington, Wright

**Montana:** Chouteau, Deer Lodge, Gallatin, Hill, Lake, Madison, Powell, Ravalli, Sanders, Wheatland, Yellowstone

**Nebraska:** Brown, Burt, Cass, Chase, Cherry, Colfax, Deuel, Dodge, Frontier, Hall, Howard, Keith, Lancaster, Merrick, Nemaha, Pawnee, Perkins, Polk, Saline, Sarpy, Valley, York

**Nevada:** Churchill, Elko, Washoe

**New Hampshire:** Belknap, Carroll, Cheshire, Grafton, Merrimack, Sullivan

**New Mexico:** Chaves, DeBaca, Roosevelt, San Juan, Union

**North Carolina:** Alleghany, Anson, Brunswick, Dare, Gaston, Jones, Lincoln, Mecklenburg, Montgomery, New Hanover, Pamlico

**North Dakota:** Adams, Emmons, Grant, McHenry, Morton, Rolette, Stark, Steele, Wells

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**Ohio:** Ashtabula, Butler, Clermont, Coshocton, Fairfield, Franklin, Hamilton, Knox, Lake, Lawrence, Medina, Morrow, Noble, Pickaway, Preble, Seneca, Summit, Tuscarawas, Van Wert, Wayne, Williams, Wood, Wyandot

**Oklahoma:** Beaver, Craig, Ellis, Garvin, Greer, Hughes, Kingfisher, Lincoln, Logan, McCurtain, Muskogee, Okfuskee, Osage, Ottawa, Pushmataha, Rogers, Stephens

**Oregon:** Deschutes, Douglas, Willowa

**Pennsylvania:** Beaver, Fulton, Huntingdon, Luzerne, Northampton, Perry, Pike, Potter, Schuylkill, Wayne

**Rhode Island:** Kent, Newport, Providence, Washington

**South Carolina:** Aiken, Dorchester, Kershaw, Union, York

**South Dakota:** Dewey, Edmunds, Hanson, Jerauld, Lyman, Marshall, McCook, McPherson, Pennington, Washabaugh

**Tennessee:** Crockett, Henry, Jackson, Lewis, McNairy, Moore, Morgan, Perry, Polk, Rutherford, White

**Texas:** Angelina, Atascosa, Austin, Borden, Camp, Cass, Collin, Crane, Dallam, Dallas, Delta, Edwards, Ellis, Fisher, Galveston, Garza, Hall, Hays, Hood, Hopkins, Johnson, Kaufman, King, Kleberg, Knox, Lee, Limestone, Martin, Montague, Nolan, Ochiltree, Oldham, Orange, Panola, Red River, San Jacinto, Sutton, Tarrant, Titus, Upton, Wheeler, Wilson, Winkler, Wood

**Utah:** Kane, Wasatch

**Vermont:** Addison, Bennington, Essex, Orange, Rutland, Washington, Windham, Windsor

**Virginia:** Covington City, Fairfax, Fairfax City, Fauquier, Frederick, Hopewell City, Loudoun, Nelson, Orange, Petersburg City, Pulaski, Rappahannock, Spotsylvania, Stafford

**Washington:** Cowlitz, Mason, Stevens

**West Virginia:** Boone, Fayette, Gilmer, Hampshire, Monroe, Morgan, Nicholas, Putnam, Ritchie, Webster, Wetzel, Wirt

**Wisconsin:** Chippewa, Door, Jefferson, Juneau, Lincoln, Marathon, Oneida, Pepin, Polk, Price, Rock, Sauk, Vilas, Wood

**Wyoming:** Albany, Carbon, Crook, Fremont, Hot Springs, Niobrara, Uinta, Weston

## Plan 5

**Alabama:** Coffee, Geneva, Lauderdale, Sumter

**Arkansas:** Dallas, Howard

**California:** Humbolt, Kings, Lake

**Connecticut:** Litchfield, Middlesex

**Delaware:** New Castle

**District of Columbia:** Washington D.C.

**Florida:** Calhoun, Lee, Polk, Wakulla

**Georgia:** Emanuel

**Illinois:** Jefferson

**Indiana:** Clay, Jefferson, Martin, Scott, Wayne

**Louisiana:** Bossier, Grant, Rapides

**Maryland:** Calvert

**Michigan:** Calhoun, Ingham, Livingston

**Mississippi:** Neshoba, Tippah, Washington

**New Jersey:** Hunterdon

**Ohio:** Huron, Mahoning, Perry, Portage

**Texas:** Anderson, Bowie, Brazoria, Clay, Deaf Smith, Dickens, Fort Bend, Gray, Harris, Liberty, McLennan, Navarro, Parker, Robertson, Travis

**Virginia:** Albemarle, Buckingham, Fredericksburg City, King George, Westmoreland, Winchester City

**West Virginia:** Calhoun, Jackson, Lewis, Mason, Ohio, Pleasants

## Plan 6

**Arkansas:** Madison, Washington

**Hawaii:** Hawaii, Honolulu

**Indiana:** De Kalb, Huntington, Wells

**Iowa:** Allamakee, Carroll, Cerro Gordo, Clay, Dickinson, Guthrie, Henry, Howard, Iowa, Jefferson, Keokuk, Mahaska, Marion, Marshall, Osceola, Union, Washington, Winnebago, Winneshiek

**New Mexico:** Bernalillo, Cibola, Sandoval, Tarrant, Valencia

**Oregon:** Clackamas, Columbia, Hood River, Marion, Multnomah, Polk, Washington

**Virginia:** Bedford City, Botetourt, Gloucester, Mathews, Newport News City, Roanoke, Williamsburg City, York

**Washington:** Clark

**Wisconsin:** Brown, Calumet, Columbia, Crawford, Dunn, Iowa, Kewaunee, Oconto, Outagamie, Pierce, Trempealeau, Winnebago

#### **Premier Plan 100**

**Alabama:** Coffee, Geneva, Lauderdale, Lee, Perry, Sumter

**Alaska:** Kenai-Cook Inlet, Matanuska-Susitna, Valdez-Cordova, Yakutat

**Arizona:** Mohave

**Arkansas:** Bradley, Dallas, Faulkner, Howard, Lonoke, Monroe, Ouachita, Van Buren, Woodruff

**California:** Del Norte, Humboldt, Santa Clara, Santa Cruz, Sonoma

**Colorado:** Huerfano, Larimer, Logan, Mesa, Phillips, Pueblo

**Florida:** Baker, Calhoun, Escambia, Franklin, Lee, Marion, Polk, Santa Rosa, Volusia, Wakulla

**Georgia:** Banks, Bibb, Bryan, Butts, Camden, Chatham, Chattooga, Clayton, Colquitt, Crawford, Dade, Effingham, Emanuel, Fannin, Fulton, Glascock, Gwinnett, Henry, Jefferson, Lincoln, Lumpkin, Macon, Mitchell, Murray, Newton, Paulding, Peach, Pickens, Spalding, Tattnall, Towns, Turner, Walker, Whitfield, Wilcox, Wilkinson

**Illinois:** Cumberland, Hardin, Jefferson, Livingston, Macoupin, Madison, Morgan, Whiteside, Williamson

**Indiana:** Bartholomew, Boone, Cass, Clay, Decatur, Fayette, Hancock, Hendricks, Jay, Jefferson, Johnson, Martin, Ohio, Scott, Shelby, Vanderburgh, Wayne

**Kansas:** Allen, Brown, Geary, Kearny, Miami, Montgomery, Osborne, Rawlins

**Louisiana:** Allen, Cameron, East Baton Rouge, Madison, Terrebonne

**Michigan:** Baraga, Calhoun, Cheboygan, Clinton, Eaton, Gratiot, Houghton, Ingham, Kalamazoo, Lapeer, Marquette, Mecosta, Midland, Muskegon, Van Buren

**Mississippi:** Attala, Chickasaw, Claiborne, George, Issaquena, Jackson, Montgomery, Panola, Pontotoc, Scott, Tate, Tippah, Washington, Wilkinson, Yazoo

**Missouri:** Adair, Audrain, Benton, Boone, Carroll, Cedar, Clinton, Gasconade, Hickory, Knox, Lafayette, Miller, Osage, Pemiscot, Putnam, Randolph, Schuyler, Sullivan, Warren, Washington

**Montana:** Lake, Madison, Yellowstone

**Nevada:** Churchill, Washoe

**New Hampshire:** Belknap

**New Mexico:** Chaves, Roosevelt, San Juan

**North Carolina:** Alleghany, Anson, Brunswick, Dare, Jones, Lincoln, New Hanover, Pamlico

**North Dakota:** Grant, Rolette

**Ohio:** Ashtabula, Butler, Coshocton, Fairfield, Franklin, Huron, Knox, Lake, Lawrence, Mahoning, Medina, Morrow, Perry, Pickaway, Preble, Seneca, Summit, Van Wert, Wayne, Williams, Wood, Wyandot

**Oklahoma:** Ellis, Garvin, Greer, Hughes, Lincoln, Logan, McCurtain, Muskogee, Okfuskee, Ottawa, Pushmataha, Rogers, Stephens

**Pennsylvania:** Beaver, Carbon, Fulton, Juniata, Lehigh, Luzerne, Northampton, Perry, Pike, Schuylkill, Wayne

**South Carolina:** Aiken, Kershaw, Union, York

**South Dakota:** Dewey, Lyman

**Tennessee:** Henry, Jackson, Lewis, Moore, Perry, Polk, Rutherford, White

**Texas:** Atascosa, Austin, Borden, Camp, Cass, Clay, Collin, Dallam, Dallas, Delta, Galveston, Hall, Hardin, Hays, Hopkins, Jefferson, Johnson, Kenedy, Knox, Lamar, Lee, Limestone, Lynn, McLennan, Medina, Montague, Morris, Navarro, Nolan, Ochiltree, Oldham, Orange, Panola, Robertson, Sutton, Wheeler, Wilson, Wood, Travis

**Vermont:** Bennington, Essex, Orange

**Virginia:** Albemarle, Bland, Buckingham, Covington City, Fairfax, Fairfax City, Fauquier, Frederick, Hopewell City, King George, Loudoun, Nelson, Orange, Petersburg City, Pulaski, Rappahannock, Spotsylvania, Stafford, Westmoreland, Winchester City

**West Virginia:** Boone, Calhoun, Fayette, Gilmer, Jackson, Lewis, Mason, Monroe, Pleasants, Putnam, Webster, Wetzel

**Wyoming:** Albany, Carbon, Fremont, Hot Springs, Weston

#### **Premier Plan 200**

**Alabama:** Barbour, Bibb, Bullock, Chambers, Elmore, Fayette, Henry, Lowndes, Madison, Montgomery, Russell, Shelby, Wilcox

**Alaska:** Kodiak Island, Nome, Barrow North Slope, Skagway-Hoonah-Angoon, Upper Yukon

**Arizona:** Apache, Cochise, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz, Yavapai

**Arkansas:** Benton, Boone, Carroll, Crawford, Franklin, Fulton, Johnson, Lee, Lincoln, Logan, Madison, Marion, Newton, Pope, Scott, Searcy, Sebastian, Washington

**California:** Alpine, Fresno, Kings, Madera, Placer, Sacramento, San Francisco, San Joaquin, Santa Barbara, Solano, Tulare, Yolo

**Colorado:** Alamosa, Archuleta, Bent, Chaffee, Conejos, Costilla, Custer, Dolores, Douglas, El Paso, Elbert, Fremont, Gilpin, Gunnison, Hinsdale, Jefferson, Kiowa, Las Animas, Lincoln, Mineral, Otero, Park, Rio Grande, Routt, Saguache, San Juan, San Miguel, Teller, Weld

**Florida:** Flagler, Gadsden, Jefferson

**Georgia:** Baldwin, Barrow, Bartow, Ben Hill, Berrien, Burke, Candler, Carroll, Catoosa, Chattahoochee, Clarke, Clay, Columbia, Coweta, Crisp, Dawson, Decatur, Dooly, Douglas, Early, Echols, Elbert, Evans, Fayette, Franklin, Grady, Greene, Habersham, Hall, Hancock, Haralson, Harris, Heard, Irwin, Jackson, Jasper, Jenkins, Jones, Lamar, Lanier, Laurens, Liberty, Madison, Marion, Meriwether, Miller, Morgan, Muscogee, Oconee, Pike, Quitman, Richmond, Rockdale, Stephens, Stewart, Sumter, Talbot, Taliaferro, Taylor, Thomas, Tift, Treutlen, Troup, Twiggs, Union, Upson, Walton, Washington, Webster, Wilkes

**Hawaii:** Hawaii, Honolulu, Kalawao, Kauai, Maui

**Idaho:** Ada, Bannock, Bear Lake, Bingham, Blaine, Boise, Boundary, Canyon, Caribou, Cassia, Clark, Custer, Franklin, Gem, Jerome, Latah, Lewis, Lincoln, Madison, Minidoka, Owyhee, Payette, Power, Twin Falls, Washington

**Illinois:** Adams, Boone, Carroll, Cass, Champaign, Clark, Clinton, Coles, Crawford, De Kalb, Douglas, Edgar, Edwards, Ford, Hancock, Henry, Jasper, Johnson, Kendall, Marshall, McLean, Menard, Mercer, Monroe, Moultrie, Ogle, Peoria, Piatt, Richland, Saline, Sangamon, Schuyler, Stark, Stephenson, Tazewell, Union, Vermilion, Winnebago, Woodford

**Indiana:** Adams, Allen, Brown, De Kalb, Dearborn, Dubois, Elkhart, Franklin, Fulton, Gibson, Grant, Hamilton, Harrison, Huntington, Jackson, Kosciusko, Lagrange, Madison, Marshall, Monroe, Morgan, Newton, Noble, Orange, Posey, Pulaski, Putnam, St. Joseph, Union, Wabash, Warrick, Washington, Wells, Whitley

**Iowa:** Adair, Allamakee, Appanoose, Audubon, Benton, Boone, Bremer, Buena Vista, Butler, Calhoun, Carroll, Cedar, Cerro Gordo, Cherokee, Chickasaw, Clarke, Clay, Clayton, Clinton, Crawford, Dallas, Davis, Decatur, Delaware, Dickinson, Emmet, Fayette, Floyd, Franklin, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Harrison, Henry, Howard, Humboldt, Ida, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Kossuth, Lee, Linn, Lousia, Lucas, Lyon, Madison, Mahaska, Marion, Marshall, Mills, Mitchell, Monroe, Muscatine, Osceola, Page, Palo Alto, Plymouth, Polk, Pottawattamie, Poweshiek, Ringgold, Sac, Scott, Sioux, Story, Tama, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Webster, Winnebago, Winneshiek, Woodbury, Worth

**Kansas:** Butler, Clay, Cloud, Cowley, Decatur, Dickinson, Franklin, Gray, Harvey, Jefferson, McPherson, Mitchell, Morris, Norton, Osage, Ottawa, Republic, Riley, Saline, Sedgwick, Smith, Sumner, Wabaunsee, Washington

**Kentucky:** Bath, Boone, Campbell, Clark, Elliott, Fayette, Harrison, Jessamine, Kenton, Lincoln, Madison, Marion, Menifee, Mercer, Montgomery, Morgan, Oldham, Powell, Rowan, Scott, Shelby, Washington, Wayne, Webster, Woodford

**Louisiana:** Ascension, Assumption, Iberville, LaFourche, Plaquemines, Pointe Coupee, St. James, St. Mary, West Baton Rouge

**Maine:** Androscoggin, Aroostook, Cumberland, Kennebec, Knox, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, York

**Maryland:** Washington

**Michigan:** Allegan, Barry, Cass, Dickinson, Emmet, Gogebic, Ionia, Kent, Lenawee, Menominee, Newaygo, Ontonagon, Otsego, Ottawa

**Minnesota:** Becker, Big Stone, Blue Earth, Brown, Carlton, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Faribault, Fillmore, Freeborn, Grant, Houston, Jackson, Kandiyohi, Kittson, Le Sueur, Lincoln, Lyon, Martin, Mecker, Morrison, Nicollet, Nobles, Otter Tail,

Pennington, Pope, Red Lake, Redwood, Rice, Rock, Roseau, Sherburne, Stearns, Steele, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona

**Mississippi:** Benton, Calhoun, Choctaw, Clay, Copiah, Lafayette, Lowndes, Madison, Marshall, Noxubee, Oktibbeha, Quitman, Tunica

**Missouri:** Barry, Bollinger, Caldwell, Cass, Christian, Clark, Cooper, Crawford, Dade, Dallas, Douglas, Franklin, Greene, Howell, Laclede, Lawrence, Livingston, Madison, Oregon, Ozark, Pettis, Polk, Ralls, Saline, Scotland, Shannon, Texas, Vernon, Wayne, Webster, Wright

**Montana:** Beaverhead, Blaine, Broadwater, Carter, Chouteau, Custer, Dawson, Deer Lodge, Fergus, Flathead, Gallatin, Garfield, Granite, Hill, Jefferson, Judith Basin, Lewis and Clark, Lincoln, McCone, Meagher, Petroleum, Powder River, Powell, Prairie, Ravalli, Richland, Sanders, Sheridan, Stillwater, Sweet Grass, Toole, Treasure, Wheatland, Wibaux

**Nebraska:** Banner, Blaine, Boone, Box Butte, Brown, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Dakota, Dawes, Dawson, Deuel, Dixon, Dodge, Fillmore, Franklin, Frontier, Furnas, Gage, Garfield, Gosper, Greeley, Hall, Hayes, Hitchcock, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lancaster, Loup, Madison, McPherson, Merrick, Morrill, Nemaha, Pawnee, Perkins, Phelps, Platte, Polk, Rock, Saline, Sarpy, Saunders, Scotts Bluff, Seward, Sheridan, Sherman, Sioux, Stanton, Valley, Washington, Wayne, Wheeler, York

**Nevada:** Elko, Esmeralda, Humboldt, Lander

**New Hampshire:** Carroll, Cheshire, Grafton, Hillsboro, Merrimack, Strafford, Sullivan

**New Mexico:** Bernalillo, Catron, Cibola, Colfax, Debaca, Dona Ana, Grant, Guadalupe, Harding, Hidalgo, Lincoln, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, San Miguel, Sandoval, Santa Fe, Sierra, Socorro, Taos, Torrance, Union, Valencia

**North Carolina:** Alamance, Alexander, Ashe, Beaufort, Bertie, Buncombe, Burke, Caldwell, Caswell, Catawba, Chatham, Cherokee, Chowan, Clay, Cumberland, Currituck, Davidson, Davie, Durham, Forsyth, Franklin, Gaston, Graham, Granville, Guilford, Haywood, Henderson, Hoke, Hyde, Jackson, Macon, Madison, Mecklenburg, Mitchell, Montgomery, Moore, Northampton, Orange, Pender, Perquimans, Person, Polk, Randolph, Rockingham, Rowan, Stokes, Tyrrell, Union, Vance, Wake, Warren, Yadkin, Yancey

**North Dakota:** Adams, Barnes, Billings, Burleigh, Cass, Cavalier, Eddy, Emmons, Golden Valley, Kidder, Logan, McHenry, McKenzie, McLean, Mercer, Morton, Mountrail, Pembina, Ramsey, Renville, Richland, Sioux, Stark, Steele, Stutsman, Traill, Ward, Wells, Williams

**Ohio:** Ashland, Brown, Carroll, Champaign, Clark, Clermont, Columbiana, Delaware, Fulton, Geauga, Greene, Hamilton, Hancock, Holmes, Licking, Marion, Miami, Montgomery, Morgan, Muskingum, Noble, Shelby, Stark, Tuscarawas, Union, Warren

**Oklahoma:** Beaver, Craig, Nowata, Osage, Sequoyah, Washington

**Oregon:** Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Douglas, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler

**Pennsylvania:** Adams, Berks, Bradford, Centre, Clinton, Columbia, Cumberland, Dauphin, Erie, Franklin, Huntingdon, Lackawanna, Lancaster, Lebanon, Lycoming, Montour, Northumberland, Potter, Snyder, Sullivan, Susquehanna, Tioga, Union, Warren, Wyoming, York

**Rhode Island:** Bristol, Kent, Newport, Providence, Washington

**South Carolina:** Allendale, Anderson, Calhoun, Cherokee, Dorchester, Edgefield, Fairfield, Greenville, Greenwood, Laurens, Newberry, Pickens, Richland, Saluda, Spartanburg

**South Dakota:** Aurora, Beadle, Bennett, Brookings, Brule, Butte, Campbell, Clark, Clay, Codington, Corson, Custer, Davison, Edmunds, Grant, Hamlin, Hand, Hanson, Hughes, Hyde, Jerauld, Kingsbury, Lake, Lawrence, Lincoln, Marshall, McCook, McPherson, Meade, Mellette, Miner, Pennington, Roberts, Sanborn, Stanley, Sully, Todd, Tripp, Walworth, Washabaugh, Yankton

**Tennessee:** Anderson, Bledsoe, Blount, Cannon, Carter, Crockett, Decatur, Hardin, Hawkins, Knox, Loudon, Marion, McMinn, McNairy, Morgan, Sequatchie, Sevier, Sullivan, Unicoi, Union, Warren

**Texas:** Aransas, Bee, Bexar, Brewster, Brooks, Carson, Chambers, Collingsworth, Concho, Crockett, Dimmit, Duval, Edwards, Frio, Glasscock, Hansford, Hartley, Haskell, Howard, Hudspeth, Irion, Jack, Jim Hogg, Jim Wells, Kinney, La Salle, Lipscomb, Live Oak, Loving, Maverick, Menard, Motley, Nueces, Presidio, Rains, Roberts, San Patricio, Shackelford, Sterling, Terrell, Throckmorton, Val Verde, Zavala

**Utah:** Box Elder, Cache, Daggett, Davis, Duchesne, Emery, Garfield, Grand, Iron, Kane, Millard, Morgan, Piute, Rich, Salt Lake, San Juan, Sevier, Summit, Tooele, Wasatch, Wayne, Weber

**Vermont:** Addison, Caledonia, Orleans, Rutland, Washington, Windham, Windsor

**Virginia:** Amelia, Appomattox, Augusta, Bedford, Bedford City, Botetourt, Brunswick, Buena Vista City, Campbell, Caroline, Carroll, Charles City, Charlotte, Chesterfield, Clarke, Craig, Culpeper, Cumberland, Danville City, Emporia, Floyd, Franklin, Franklin City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greenville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Henry, Highland, Isle of Wight, King and Queen, King William, Lancaster, Louisa, Lunenburg, Lynchburg City, Madison, Manassas City, Manassas Park City, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Nottoway, Page, Pittsylvania, Poquoson City, Portsmouth

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City, Powhatan, Prince Edward, Prince George, Prince William, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Salem, Scott, Shenandoah, Smyth, Southampton, Staunton City, Suffolk City, Surry, Sussex, Virginia Beach City, Warren, Washington, Waynesboro City, Williamsburg City, Wythe, York

**Washington:** Clallam, Clark, Columbia, Cowlitz, Island, King, Kitsap, Kittitas, Klickitat, Mason, Pierce, San Juan, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Yakima

**West Virginia:** Berkeley, Braxton, Cabell, Clay, Doddridge, Grant, Hampshire, Hardy, Jefferson, Kanawha, Lincoln, Morgan, Nicholas, Pendleton, Ritchie, Roane, Tucker, Upshur, Wayne, Wirt

**Wisconsin:** Ashland, Barron, Bayfield, Brown, Buffalo, Burnett, Calumet, Chippewa, Columbia, Crawford, Dane, Dodge, Door, Douglas, Dunn, Eau Claire, Florence, Fond Du Lac, Forest, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kenosha, Kewaunee, La Crosse, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Monroe, Oconto, Oneida, Outagamie, Ozaukee, Pepin, Pierce, Polk, Portage, Price, Racine, Richland, Rock, Rusk, Sauk, Sawyer, Shawano, Sheboygan, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Washburn, Washington, Waukesha, Waupaca, Waushara, Winnebago, Wood

**Wyoming:** Crook, Goshen, Johnson, Niobrara, Park, Sheridan, Uinta

*Effective April 14, 2003*

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. NO ACTION IS REQUIRED ON YOUR PART.

At PacifiCare the protection of our members' privacy and the confidentiality of medical information has always been a top priority. We recognize that you depend upon us to safeguard your personal information and uphold your privacy rights. This document, which is based on state and federal law, as well as our own company code of ethics, offers a declaration of our commitment to preserving member confidentiality and privacy.

### Our Privacy Practices

This notice describes PacifiCare's privacy practices for both current and former members. It explains how we use health information about you and when we may share that health information with others. It also informs you about your rights with respect to your health information and how you may exercise these rights. We are required by law to maintain the privacy of your health information and to send you a copy of this notice so that you are aware of how we maintain the privacy of your health information.

PacifiCare employees are required to comply with our policies and procedures to protect the confidentiality of health information. Any employee who violates our privacy policy is subject to a disciplinary process. Employee access to health information is limited on a business "need-to-know" basis, such as: to make benefit determinations, pay claims, manage care, underwrite coverage, perform quality assessment measurements, administer a plan or provide customer service.

PacifiCare maintains physical, electronic and process safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets, and controlled computer network systems and password accounts.

This notice applies to all applicable companies within the PacifiCare family of companies, which includes businesses owned or controlled by PacifiCare Health Systems, Inc. (PacifiCare).

Please share this notice with everyone covered by your policy or contract. You have a right to receive a copy of this notice upon request at any time. If you would like additional copies of the notice, or have questions related to the information contained within the notice, please call Member/ Customer Services at the toll-free number on your health plan identification card. You may also view a copy of this notice on our Web sites at [www.pacificare.com](http://www.pacificare.com) and [www.securehorizons.com](http://www.securehorizons.com).

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all health information that we maintain. We will provide you a copy of the revised notice and post the revised notice on our Web sites.

### Health Care Information Maintained at PacifiCare

When we refer to "information" or "health information" in this notice, we mean information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services. Health information may be transmitted or shared in any form or medium (oral, written, or electronic).

The health information we receive may vary by product; therefore, the examples that follow may not apply to all members, but are designed to represent the general categories of information that may be received and maintained by PacifiCare:

- Information provided by you on applications, forms, surveys and our Web sites, such as your name, address and date of birth

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

- Information from physicians, hospitals or other health care providers, clinics, medical groups or health care service plans
- Information provided by your employer, benefits plan sponsor or association, regarding any group product that you may have
- Information about your transactions and experiences with our affiliates, others, and us, such as products or services purchased, account balances, payment history, claims history, policy coverage and premiums
- Information from consumer or medical reporting agencies or other third parties, including medical and demographic information

### **How We May Use or Share Your Information**

The following categories describe how we may use and share your health information. For each category we provide examples that help illustrate each type of use or disclosure. Not every use or disclosure in a category will be listed. However, the ways in which we are permitted to use and share health information will fall into one of these categories.

#### **For Treatment**

We may share health information with your doctors or hospitals to help them provide medical care for you. For example, if you are hospitalized, we may allow the hospital staff access to any medical records sent to us by your doctor. We may also use or share your health information with others to help coordinate and manage your health care. For example, we may talk to your doctor to suggest a disease management or wellness program that can help improve your health.

#### **For Payment**

We may use your health information when paying your medical bills submitted to us by you or your health care providers, such as doctors and hospitals. Examples of payment activities include billing, claims management and other related administrative functions.

### **For Health Care Operations**

We may use or share certain health information for necessary health care operations. Examples of health care operations include the following:

- Performing quality assessment and improvement activities
- Evaluating provider and health plan performance
- Providing underwriting coverage
- Conducting or arranging medical reviews to determine medical necessity, level of care or justification of services
- Performing auditing functions
- Resolving internal grievances, such as addressing problems or complaints about your access to care or satisfaction with services
- Making benefit determinations, administering a benefit plan and providing customer service
- Other uses specifically authorized by law

We may also share your health information with other individuals or entities, also known as business associates, that perform payment or health care operations on behalf of PacifiCare. However, we will not share your health information with these business associates unless they agree in writing to protect the privacy of that information.

### **To Make Certain Communications to You**

We may use or share your health information with a third party acting on behalf of PacifiCare in order to inform you about alternative medical treatments and programs or about health-related products and services that may be of value to you. We may also inform you about enhancements, replacements or substitutions to your health plan coverage.

*For members that reside in Oregon and Nevada, if you do not want PacifiCare to share health information as described above, you may "opt-out" by calling the Member/Customer Service toll-free number on your health plan identification card during normal business hours.*

### Information Not Personally Identifiable

We may use or share your health information when it has been "de-identified." Health information is considered to be de-identified when it does not personally identify you.

We may also use a "limited data set" that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or health care operations. For example, a limited data set may include your city, county and zip code, but not your name or street address.

### To the Employee Benefit Plan

Under certain circumstances, we may share limited health information about you with the employee benefit plan through which you receive health benefits. For example, we may share summary health information with the employee benefit plan so that they may obtain bids from other health plans, or modify, amend, or terminate coverage with PacifiCare. We may also share health information related to your enrollment, disenrollment and/or participation in a PacifiCare health plan. We will not share individually identifiable health information with your benefit plan unless they agree to maintain the privacy of your information.

*For members that reside in California, PacifiCare may not share your health information with your employer or benefit plan unless you provide written permission for us to do so.*

### Special Circumstances and State and Federal Laws

Special situations and certain state and federal laws may require us to use or release your health information. For example, we may be obligated to release your health information for the following reasons:

- To comply with state and federal laws that require us to release your health information to others
- To report information to state and federal agencies that regulate our business, such as the U.S. Department of Health and Human Services and your state's regulatory agencies
- To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating or tracking a prescription drug and medical device malfunctions
- To report information to public health agencies if we believe there is a serious threat to your health and safety or that of the public or another person; this includes disaster relief efforts
- To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer review activities
- To assist court or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
- To report information to a government authority regarding child abuse, neglect or domestic violence
- To share information with a coroner or medical examiner as authorized by law (we may also share information with funeral directors, as necessary to carry out their duties)
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues
- To report information regarding job-related injuries as required by your state worker compensation laws
- To share information related to specialized government functions, such as military and veteran activities, national security and intelligence activities and protective services

*Customer Service 1-866-272-0407 (TTY 1-888-844-5530), 8 a.m. to 10 p.m. EST, Monday through Friday.*

for the President and others

- To researchers when their research has been approved by an institutional review board that has approved the research proposal and established protocols to ensure the privacy of your health information
- To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure; (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstances, based on PacifiCare's professional judgment, that you would not object

### **Written Permission to Use or Share Your Information**

For any other activity or purpose not listed above or as otherwise permitted by law we must obtain your written permission, known as an authorization, prior to using or sharing your health information. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time.

Once an authorization has been revoked, we will no longer use or share the health information as outlined in the authorization form; however, you should be aware that we may not be able to retract a use or disclosure that was previously made based on a valid authorization.

### **Other Restrictions Regarding Use and Disclosure of Your Information**

Depending on the state in which you reside, there may be additional laws related to the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health and mental retardation.

### **Your Rights Regarding Your Health Information**

The following are your rights with respect to your health information. If you would like to exercise the following rights, please call Member/Customer Services at the toll-free number on your health plan identification card.

You have the right to ask us to restrict how we use or share your health information for treatment, payment or health care operations. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care.

Please note that while we will try to honor your requests, we are not required by law to agree to the type of restrictions described above.

You have the right to request confidential communications of health information. For example, if you believe that sending your information to your current mailing address would put your safety at risk (e.g., in situations involving domestic disputes or violence), you may ask us to send the information by alternative means (such as by fax) or to an alternate address. We will accommodate reasonable requests for confidential communication of your information.

You have the right to inspect and obtain a copy of the health information we maintain about you in a designated record set. A designated record set refers to a group of records that includes enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for PacifiCare. The types of health information included in a designated record set may vary depending on the state in which you reside.

This right does not obligate us to grant you access to certain types of health information. Please note that under most circumstances we will not provide you with copies of the following information:

- Psychotherapy notes
- Information compiled in reasonable anticipation of, or for use in, a civil or criminal administrative action or proceeding

- Information subject to certain federal laws governing biological products and clinical laboratories
- Medical information compiled and used for quality assurance or peer review purposes

If you request a copy of your designated record set, a fee for the costs of copying, mailing or other associated supplies may be charged.

Additionally, under certain circumstances we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

If you would like to request access to review or copy your patient medical records, please directly contact your Primary Care Physician or the health care provider who created the records. Patient medical records include records in any form or medium maintained by, or in the custody or control of, a health care provider relating to health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient.

You have the right to ask us to make changes to the health information that we maintain about you in your designated record set. These changes are referred to as amendments. We may require that your request be in writing and that you provide a reason for your request.

If we make the amendment, we will notify you that it was made. If we deny your request to amend, we will notify you in writing of the reason for denial. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement of disagreement be included with your health information for any future disclosures.

You have the right to receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request for an accounting be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please note that, under most circumstances, we are not required to provide you with an accounting of disclosures of the following information:

- Any information collected prior to April 14, 2003
- Information shared for treatment, payment or health care operations
- Information already disclosed to you
- Information shared as part of an authorization request
- Information that is incidental to a use or disclosure that is otherwise permitted
- Information provided for use in a facility directory
- Information that was provided to persons involved in your care or for other notification purposes
- Information shared for national security or intelligence purposes
- Information that was shared or used as part of a limited data set for research, public health or health care operation purposes
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies

## Questions Regarding Use and Disclosure and Your Privacy Rights

### How to File a Privacy Complaint

If you believe that your privacy rights have been violated, you may file a complaint with us by calling PacifiCare's Privacy Line at 1-800-481-6982. You may also direct your complaints to the Secretary of the U.S. Department of Health and Human Services.

PacifiCare will not penalize you or take any action against you for filing a complaint.

## How to Obtain More Information Regarding Your Rights as Well as the Use and Disclosure of Your Health Information.

If you have any questions about how we use or share your health information or your rights regarding your health information, you may call Member/Customer Services at the toll-free number on your health plan identification card during normal business hours.

### PacifiCare Family of Companies includes:

|                                                         |                                                  |
|---------------------------------------------------------|--------------------------------------------------|
| PacifiCare Health Systems, Inc.                         | American Medical Security Life Insurance Company |
| PacifiCare eHoldings                                    | Continental Plan Services, Inc.                  |
| PacifiCare Heath Systems Foundation                     | FHP Reinsurance Limited                          |
| PacifiCare Health Plan Administrators, Inc.             | PacifiCare Advantage, Inc.                       |
| PacifiCare Insurance Company                            | PacifiCare of Arizona, Inc.                      |
| SeniorCo, Inc.                                          | PacifiCare of Oregon, Inc.                       |
| RxSolutions, Inc.                                       | PacifiCare of California                         |
| PacifiCare Behavioral Health, Inc.                      | PacifiCare of Texas, Inc.                        |
| PacifiCare Behavioral Health of California, Inc.        | PacifiCare of Washington, Inc.                   |
| PacifiCare Behavioral Health of New Jersey, Inc.        | PacifiCare of Oklahoma, Inc.                     |
| PacifiCare Behavioral Health NY IPA, Inc.               | PacifiCare of Nevada, Inc.                       |
| Secure Horizons USA, Inc.                               | PacifiCare of Colorado, Inc.                     |
| PacifiCare International Ltd.                           | PacifiCare Southwest Operations, Inc.            |
| PacifiCare Dental                                       | Antero Health Plans, Inc.                        |
| PacifiCare Dental of Colorado, Inc.                     | Union Health Solutions, Inc.                     |
| PacifiCare Asia Pacific Insurance Brokers, Inc.         | Coadvantage, LLC.                                |
| PacifiCare Health Insurance Company of Micronesia, Inc. | Nurse Healthline, Inc.                           |
| PacifiCare Life and Health Insurance Company            | Alere Medical Incorporated                       |
| PacifiCare Life Assurance Company                       | Salveo Holdings, LLC                             |
| American Medical Security Group, Inc.                   | Salveo Insurance Company Ltd.                    |



SecureHorizons Direct<sup>SM</sup>  
P.O. Box 4169  
Scranton, PA 18505

**Customer Service**  
1-866-272-0407  
TTY 1-888-844-5530  
8 a.m. to 10 p.m. EST  
Monday through Friday

**Sales Information**  
1-800-776-8876  
TTY 1-800-387-1074

Visit our Web site at  
[www.securehorizons.com](http://www.securehorizons.com)

*Before you seek Covered Services, Providers must be informed of your SecureHorizons Direct<sup>SM</sup> membership and accept PacifiCare Life and Health Insurance Company Terms and Conditions. Hospitals and most other non-physician providers must accept Medicare Assignment. However, if a non-participating physician, physical therapist, occupational therapist or Durable Medical Equipment supplier does not accept Medicare Assignment, you may incur expenses not covered by SecureHorizons Direct<sup>SM</sup>. Please contact SecureHorizons Direct<sup>SM</sup> for details.*

*You must be entitled to Medicare Part A and enrolled in Medicare Part B. You must continue to pay the Medicare Part B premium and live in the SecureHorizons Direct<sup>SM</sup> covered service area. If you currently have End Stage Renal Disease (ESRD) and receive routine dialysis treatment to maintain life, you may not enroll in SecureHorizons Direct<sup>SM</sup> unless you are currently a PacifiCare Commercial plan member.*

*SecureHorizons Direct<sup>SM</sup>, a Medicare Advantage Private Fee-For-Service Plan, is offered by PacifiCare Life and Health Insurance Company, which contracts with the federal government. Limitations, copayments and coinsurance will apply. Health plan premiums and plan benefits may vary by state and county. You must see a deemed provider, which is a provider who agrees to accept PLHIC's payment terms and conditions. PacifiCare, A UnitedHealthcare Company.*

**SecureHorizons Direct<sup>SM</sup>**  
from **PacifiCare**  
A Private Fee for Service Health Plan

# **Exhibit 3**

SecureHorizons Direct<sup>SM</sup>

from **PacifiCare**®

*A Private Fee for Service Health Plan*

## SUMMARY OF BENEFITS

**SecureHorizons Direct<sup>SM</sup>**

■ Plan 4



Benefits Effective January 1, 2006

Areas of Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming

H5435



## SECTION I: Introduction to the Summary of Benefits

### SecureHorizons Direct<sup>SM</sup> Plan 4

January 1, 2006 – December 31, 2006 ■ Multi-State: Area 4 – H5435

Thank you for your interest in SecureHorizons Direct<sup>SM</sup> Plan 4. Our plan is offered by PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, a Medicare Advantage Private Fee-for-Service organization. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call SecureHorizons Direct<sup>SM</sup> Plan 4 and ask for the "Evidence of Coverage."

#### You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like SecureHorizons Direct<sup>SM</sup> Plan 4. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call SecureHorizons Direct<sup>SM</sup> Plan 4 at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

#### How Can I Compare My Options?

You can compare SecureHorizons Direct<sup>SM</sup> Plan 4 and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

#### Where Is SecureHorizons Direct<sup>SM</sup> Plan 4 Available?

The complete service area for SecureHorizons Direct<sup>SM</sup> Plan 4 is listed on page 3 of this document.

#### Can I Choose My Doctors?

As a member of SecureHorizons Direct<sup>SM</sup> Plan 4, you can go to any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate of the SecureHorizons Direct<sup>SM</sup> plan. SecureHorizons Direct<sup>SM</sup> has the right to determine if the service or treatment ordered by your health care provider is covered under the SecureHorizons Direct<sup>SM</sup> plan.

#### Where Can I Get My Prescriptions If I Join This Plan?

As a member of SecureHorizons Direct<sup>SM</sup> Plan 4, you can use any pharmacy that accepts Medicare payment and accepts the terms and conditions of the SecureHorizons Direct<sup>SM</sup> plan. SecureHorizons Direct<sup>SM</sup> has the right to determine if the prescription ordered by your health care provider is covered under the SecureHorizons Direct<sup>SM</sup> plan.

#### Does My Plan Cover Medicare Part B Or Part D Drugs?

SecureHorizons Direct<sup>SM</sup> Plan 4 does cover Medicare Part B Prescription drugs. SecureHorizons Direct<sup>SM</sup> Plan 4 does NOT cover Medicare Part D prescription drugs.

## SECTION I: Introduction to the Summary of Benefits

### SecureHorizons Direct<sup>SM</sup> Plan 4

#### What Types Of Drugs May Be Covered Under Medicare Part B?

The following outpatient prescription drugs may be covered under the Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact SecureHorizons Direct<sup>SM</sup> Plan 4 for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a Primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and infusion drugs** provided through DME.

Please call SecureHorizons Direct<sup>SM</sup> for more information about this plan.

Visit us at [www.securehorizons.com](http://www.securehorizons.com) or, call us:

Customer Service Hours:

8 a.m. to 10 p.m. EST, Monday – Friday  
Current enrollees should call 1-866-579-8774 (TTY 1-888-685-8480).

Prospective enrollees should call 1-800-776-8876 (TTY/TDD 1-800-387-1074), 6 a.m. to 7 p.m. PST, Monday – Friday and 8 a.m. to 12 p.m. PST, Saturday.

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-800-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.



**SECTION I: Introduction to the Summary of Benefits****Service Area for SecureHorizons Direct<sup>SM</sup>**

SecureHorizons Direct<sup>SM</sup> is available in selected counties in all states (except New York) and the District of Columbia. Each service area may have different health plan premium and cost sharing amounts.

This Summary of Benefits is for Plan 4 service area. If you would like information on benefit plans available in other areas, including health plan premium and cost sharing amounts, please contact SecureHorizons Direct<sup>SM</sup> Customer Service at 1-866-579-8774, or for the hearing impaired, TTY 1-888-685-8480, 8 a.m. to 10 p.m. EST, Monday through Friday.

**SecureHorizons Direct<sup>SM</sup>  
Plan 4 Service Area**

| <b>STATE</b>      | <b>COUNTIES</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Alabama</b>    | Barbour, Chambers, Fayette, Lee, Perry, Wilcox                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Alaska</b>     | Kenai Peninsula, Matanuska-Susitna, Skagway-Hoonah-Angoon, Yakutat                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Arizona</b>    | Apache, Greenlee, Maricopa, Mohave, Pinal                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Arkansas</b>   | Bradley, Faulkner, Fulton, Johnson, Lee, Lincoln, Lonoke, Monroe, Ouachita, Pope, Van Buren, Woodruff                                                                                                                                                                                                                                                                                                                                    |
| <b>California</b> | Napa, Santa Clara, Santa Cruz, Sonoma                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Colorado</b>   | Bent, Conejos, Costilla, Custer, Huerfano, Jefferson, Larimer, Logan, Phillips, Pueblo, Teller                                                                                                                                                                                                                                                                                                                                           |
| <b>Florida</b>    | Baker, Escambia, Gadsden, Marion, Santa Rosa, Volusia                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Georgia</b>    | Baldwin, Banks, Bibb, Bryan, Butts, Camden, Carroll, Chatham, Chattooga, Clayton, Colquitt, Crawford, Dade, Effingham, Fannin, Franklin, Fulton, Glascock, Greene, Gwinnett, Hall, Heard, Henry, Houston, Jefferson, Laurens, Liberty, Lincoln, Lumpkin, Macon, Miller, Mitchell, Murray, Newton, Paulding, Pickens, Spalding, Stewart, Taliaferro, Tattnall, Thomas, Towns, Turner, Twiggs, Upson, Walker, Whitfield, Wilcox, Wilkinson |
| <b>Idaho</b>      | Bannock, Blaine, Boundary, Custer, Latah, Lewis, Madison, Payette, Washington                                                                                                                                                                                                                                                                                                                                                            |
| <b>Illinois</b>   | Adams, Cumberland, Ford, Hardin, Kendall, Livingston, Macoupin, Madison, Morgan, Richland, Saline, Sangamon, Vermilion, Whiteside, Williamson                                                                                                                                                                                                                                                                                            |
| <b>Indiana</b>    | Bartholomew, Boone, Cass, Decatur, Dubois, Fayette, Grant, Hamilton, Hancock, Hendricks, Jay, Johnson, Ohio, Pulaski, Shelby, Union, Vanderburgh, Warrick                                                                                                                                                                                                                                                                                |
| <b>Iowa</b>       | Bremer, Sac                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Kansas</b>     | Allen, Bourbon, Brown, Clay, Geary, Gray, Jefferson, Kearny, McPherson, Miami, Montgomery, Norton, Osage, Osborne, Pratt, Rawlins, Riley, Sedgwick, Sumner, Wabaunsee, Washington                                                                                                                                                                                                                                                        |
| <b>Kentucky</b>   | Boone, Harrison, Lincoln, Mercer, Morgan, Rowan, Washington, Wayne                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Louisiana</b>  | Allen, Calcasieu, Cameron, East Baton Rouge, East Feliciana, St. John Baptist, Terrebonne, Washington                                                                                                                                                                                                                                                                                                                                    |
| <b>Maine</b>      | Androscoggin, Knox, Penobscot, Piscataquis, Somerset, Waldo, Washington                                                                                                                                                                                                                                                                                                                                                                  |

**SECTION I: Introduction to the Summary of Benefits****Service Area for SecureHorizons Direct<sup>SM</sup>****SecureHorizons Direct<sup>SM</sup>  
Plan 4 Service Area (continued)**

| <b>STATE</b>          | <b>COUNTIES</b>                                                                                                                                                                                                                             |
|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Massachusetts</b>  | Dukes, Franklin                                                                                                                                                                                                                             |
| <b>Michigan</b>       | Baraga, Cheboygan, Clinton, Eaton, Emmet, Houghton, Kalamazoo, Marquette, Mecosta, Midland, Muskegon, Van Buren                                                                                                                             |
| <b>Minnesota</b>      | Becker, Clay, Fillmore, Meeker, Pope, Rice, Stearns, Wadena                                                                                                                                                                                 |
| <b>Mississippi</b>    | Attala, Chickasaw, Choctaw, Claiborne, Clay, Copiah, George, Jackson, Madison, Montgomery, Panola, Pontotoc, Scott, Tate, Wilkinson, Yazoo                                                                                                  |
| <b>Missouri</b>       | Adair, Audrain, Barry, Benton, Bollinger, Boone, Carroll, Cedar, Clinton, Cooper, Gasconade, Hickory, Knox, Lafayette, Lawrence, Madison, Miller, Osage, Pemiscot, Pettis, Putnam, Randolph, Schuyler, Sullivan, Warren, Washington, Wright |
| <b>Montana</b>        | Chouteau, Deer Lodge, Gallatin, Hill, Lake, Madison, Powell, Ravalli, Sanders, Wheatland, Yellowstone                                                                                                                                       |
| <b>Nebraska</b>       | Brown, Burt, Cass, Chase, Cherry, Colfax, Deuel, Dodge, Frontier, Hall, Howard, Keith, Lancaster, Merrick, Nemaha, Pawnee, Perkins, Polk, Saline, Sarpy, Valley, York                                                                       |
| <b>Nevada</b>         | Churchill, Elko, Washoe                                                                                                                                                                                                                     |
| <b>New Hampshire</b>  | Belknap, Carroll, Cheshire, Grafton, Merrimack, Sullivan                                                                                                                                                                                    |
| <b>New Mexico</b>     | Chaves, DeBaca, Roosevelt, San Juan, Union                                                                                                                                                                                                  |
| <b>North Carolina</b> | Alleghany, Anson, Brunswick, Dare, Gaston, Jones, Lincoln, Mecklenburg, Montgomery, New Hanover, Pamlico                                                                                                                                    |
| <b>North Dakota</b>   | Adams, Emmons, Grant, McHenry, Morton, Rolette, Stark, Steele, Wells                                                                                                                                                                        |
| <b>Ohio</b>           | Ashtabula, Butler, Clermont, Coshocton, Fairfield, Franklin, Hamilton, Knox, Lake, Lawrence, Medina, Morrow, Noble, Pickaway, Preble, Seneca, Summit, Tuscarawas, Van Wert, Wayne, Williams, Wood, Wyandot                                  |
| <b>Oklahoma</b>       | Beaver, Craig, Ellis, Garvin, Greer, Hughes, Kingfisher, Lincoln, Logan, McCurtain, Muskogee, Okfuskee, Osage, Ottawa, Pushmataha, Rogers, Stephens                                                                                         |
| <b>Oregon</b>         | Deschutes, Douglas, Wallowa                                                                                                                                                                                                                 |
| <b>Pennsylvania</b>   | Beaver, Fulton, Huntingdon, Luzerne, Northampton, Perry, Pike, Potter, Schuylkill, Wayne                                                                                                                                                    |
| <b>Rhode Island</b>   | Kent, Newport, Providence, Washington                                                                                                                                                                                                       |
| <b>South Carolina</b> | Aiken, Dorchester, Kershaw, Union, York                                                                                                                                                                                                     |
| <b>South Dakota</b>   | Dewey, Edmunds, Hanson, Jerauld, Lyman, Marshall, McCook, McPherson, Pennington, Washabaugh                                                                                                                                                 |
| <b>Tennessee</b>      | Crockett, Henry, Jackson, Lewis, McNairy, Moore, Morgan, Perry, Polk, Rutherford, White                                                                                                                                                     |

**SECTION I: Introduction to the Summary of Benefits****Service Area for SecureHorizons Direct<sup>SM</sup>****SecureHorizons Direct<sup>SM</sup>  
Plan 4 Service Area (continued)**

| <b>STATE</b>         | <b>COUNTIES</b>                                                                                                                                                                                                                                                                                                                                                     |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Texas</b>         | Angelina, Atascosa, Austin, Borden, Camp, Cass, Collin, Crane, Dallam, Dallas, Delta, Edwards, Ellis, Fisher, Galveston, Garza, Hall, Hays, Hood, Hopkins, Johnson, Kaufman, King, Kleberg, Knox, Lee, Limestone, Martin, Montague, Nolan, Ochiltree, Oldham, Orange, Panola, Red River, San Jacinto, Sutton, Tarrant, Titus, Upton, Wheeler, Wilson, Winkler, Wood |
| <b>Utah</b>          | Kane, Wasatch                                                                                                                                                                                                                                                                                                                                                       |
| <b>Vermont</b>       | Addison, Bennington, Essex, Orange, Rutland, Washington, Windham, Windsor                                                                                                                                                                                                                                                                                           |
| <b>Virginia</b>      | Covington City, Fairfax, Fairfax City, Fauquier, Frederick, Hopewell City, Loudon, Nelson, Orange, Petersburg City, Pulaski, Rappahannock, Spotsylvania, Stafford                                                                                                                                                                                                   |
| <b>Washington</b>    | Cowlitz, Mason, Stevens                                                                                                                                                                                                                                                                                                                                             |
| <b>West Virginia</b> | Boone, Fayette, Gilmer, Hampshire, Monroe, Morgan, Nicholas, Putnam, Ritchie, Webster, Wetzel, Wirt                                                                                                                                                                                                                                                                 |
| <b>Wisconsin</b>     | Chippewa, Door, Jefferson, Juneau, Lincoln, Marathon, Oneida, Pepin, Polk, Price, Rock, Sauk, Vilas, Wood                                                                                                                                                                                                                                                           |
| <b>Wyoming</b>       | Albany, Carbon, Crook, Fremont, Hot Springs, Niobrara, Uinta, Weston                                                                                                                                                                                                                                                                                                |

**SECTION II: Summary of Benefits****BENEFIT CATEGORY****Original Medicare****SecureHorizons Direct<sup>SM</sup> Plan 4****Important Information****1 Premium and Other Important Information**

You pay the Medicare Part B premium of \$88.50 each month.

You pay \$25 each month for your plan benefits.

You also continue to pay the Medicare Part B premium of \$88.50 each month.

There is a \$3,000 maximum out-of-pocket limit every year.

(See page 14 for information on Premium and Other Important Information.)

**2 Doctor and Hospital Choice**  
(For more information, see Emergency - #15 and Urgently Needed Care - #16.)

You may go to any doctor, specialist or hospital that accepts Medicare.

You may go to any doctor, specialist or hospital that accepts the plan's payment.

(See page 14 for information on Doctor and Hospital Choice.)

**Inpatient Care****3 Inpatient Hospital Care**  
(includes Substance Abuse and Rehabilitation Services)

You pay for each benefit period:<sup>Ⓐ</sup>

Days 1-60: an initial deductible of \$952

Days 61-90: \$238 each day

Days 91-150: \$476 each lifetime reserve day<sup>Ⓐ</sup>

Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.<sup>Ⓐ</sup>

You pay:

\$200 each day for day(s) 1-4

\$0 each day for day(s) 5-90

for a Medicare-covered stay at a hospital.

There is no copayment for additional days received at a hospital.

You are covered for unlimited days each benefit period.

You may go to any doctor, specialist or hospital that accepts the plan's payment.

(See page 15 for information on Inpatient Hospital Care.)

<sup>Ⓐ</sup> A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

<sup>Ⓐ</sup> Lifetime reserve days can only be used once.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION II: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>                                                                                                                                  | <b>Original Medicare</b>                                                                                                                                                                                                                                 | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>4 Inpatient Mental Health Care</b>                                                                                                                    | You pay the same deductible and copayments as inpatient hospital care except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.                                                                                   | <p>You pay:</p> <p>\$200 each day for day(s) 1-4</p> <p>\$0 each day for day(s) 5-90</p> <p>for a Medicare-covered stay at a hospital.</p> <p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p> <p>(See page 15 for information on Inpatient Mental Health Care.)</p>  |
| <b>5 Skilled Nursing Facility (in a Medicare-certified Skilled Nursing Facility)</b>                                                                     | <p>You pay for each benefit period,<sup>Ⓐ</sup> following at least a 3-day covered hospital stay:</p> <p>Days 1-20: \$0 for each day</p> <p>Days 21-100: \$119 for each day</p> <p>There is a limit of 100 days for each benefit period.<sup>Ⓐ</sup></p> | <p>You pay:</p> <p>\$0 each day for day(s) 1-10</p> <p>\$115 each day for day(s) 11-100</p> <p>for a stay at a Skilled Nursing Facility.</p> <p>No prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period.</p> <p>(See page 15 for information on Skilled Nursing Facility.)</p> |
| <b>6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</b> | There is no copayment for all covered home health visits.                                                                                                                                                                                                | There is no copayment for Medicare-covered home health visits.                                                                                                                                                                                                                                                     |
| <b>7 Hospice</b>                                                                                                                                         | <p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>                                                                                                         | You must receive care from a Medicare-certified hospice.                                                                                                                                                                                                                                                           |

<sup>Ⓐ</sup> A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

## SECTION II: Summary of Benefits

### BENEFIT CATEGORY

### Original Medicare

### SecureHorizons Direct<sup>SM</sup> Plan 4

#### Outpatient Care

#### 8 Doctor Office Visits

You pay 20% of Medicare-approved amounts.<sup>••</sup>

You pay \$10 for each primary care doctor office visit for Medicare-covered services.

You pay \$20 for each specialist visit for Medicare-covered services.

You may go to any doctor, specialist, or hospital that accepts the plan's payment.

See 32 - Physical Exams for more information.

#### 9 Chiropractic Services

You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.

You pay 100% for routine care.

You pay 20% of Medicare-approved amounts.<sup>••</sup>

You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).

#### 10 Podiatry Services

You pay 20% of Medicare-approved amounts.<sup>••</sup>

You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.

You pay 100% for routine care.

You pay \$20 for each Medicare-covered visit (medically necessary foot care).

#### 11 Outpatient Mental Health Care

You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges.<sup>••</sup>

For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.

• Each year, you pay a total of one \$124 deductible.

• If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION II: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>                                                                                           | <b>Original Medicare</b>                                                                                                                                                                                                                                                                                                                                   | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>12 Outpatient Substance Abuse Care</b>                                                                         | You pay 20% of Medicare-approved amounts. <sup>❶</sup>                                                                                                                                                                                                                                                                                                     | For Medicare-covered services, you pay \$25 for each individual/group visit.                                                                                         |
| <b>13 Outpatient Services/Surgery</b>                                                                             | You pay 20% of Medicare-approved amounts for the doctor. <sup>❶</sup><br>You pay 20% of outpatient facility charges. <sup>❶</sup>                                                                                                                                                                                                                          | You pay \$100 for each Medicare-covered visit to an ambulatory surgical center.<br>You pay \$100 for each Medicare-covered visit to an outpatient hospital facility. |
| <b>14 Ambulance Services</b><br>(medically necessary ambulance services)                                          | You pay 20% of Medicare-approved amounts or applicable fee schedule charge. <sup>❶</sup>                                                                                                                                                                                                                                                                   | You pay \$150 for Medicare-covered ambulance services.                                                                                                               |
| <b>15 Emergency Care</b><br>(You may go to any emergency room if you reasonably believe you need emergency care.) | You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. <sup>❶</sup><br>You pay 20% of doctor charges. <sup>❶</sup><br>NOT covered outside the U.S. except under limited circumstances. | You pay \$50 for each Medicare-covered emergency room visit.<br>Worldwide coverage.<br>(See page 16 for information on Emergency Care.)                              |
| <b>16 Urgently Needed Care</b><br>(This is NOT emergency care, and in most cases, is out of the service area.)    | You pay 20% of Medicare-approved amounts or applicable copayment. <sup>❶</sup><br>NOT covered outside the U.S. except under limited circumstances.                                                                                                                                                                                                         | You pay \$40 for each Medicare-covered urgently needed care visit.<br>Worldwide coverage.<br>(See page 16 for information on Urgently Needed Care.)                  |

❶ Each year, you pay a total of one \$124 deductible.

❷ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION II: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>                                                                                               | <b>Original Medicare</b>                                | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>17 Outpatient Rehabilitation Services</b><br>(Occupational Therapy, Physical Therapy, Speech and Language Therapy) | You pay 20% of Medicare-approved amounts. <sup>❶❷</sup> | You pay \$25 for each Medicare-covered Occupational Therapy visit.<br>You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. |

**Outpatient Medical Services and Supplies**

|                                                                                                                                                          |                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>18 Durable Medical Equipment</b><br>(includes wheelchairs, oxygen, etc.)                                                                              | You pay 20% of Medicare-approved amounts. <sup>❶❷</sup>                                                                                                    | You pay 30% of the cost for each Medicare-covered item.                                                                                                                                                                                                                                                              |
| <b>19 Prosthetic Devices</b><br>(includes braces, artificial limbs and eyes, etc.)                                                                       | You pay 20% of Medicare-approved amounts. <sup>❶❷</sup>                                                                                                    | You pay 30% of the cost for each Medicare-covered item.                                                                                                                                                                                                                                                              |
| <b>20 Diabetes Self-Monitoring Training and Supplies</b><br>(includes coverage for glucose monitors, test strips, lancets, and self-management training) | You pay 20% of Medicare-approved amounts. <sup>❶❷</sup>                                                                                                    | There is no copayment for Diabetes self-monitoring training.<br>You pay 20% of the cost for each Medicare-covered Diabetes Supply item.                                                                                                                                                                              |
| <b>21 Diagnostic Tests, X-rays and Lab Services</b>                                                                                                      | You pay 20% of Medicare-approved amounts, except for approved lab services. <sup>❶❷</sup><br><br>There is no copayment for Medicare-approved lab services. | You pay:<br><br>\$0 for each Medicare-covered clinical/diagnostic lab service.<br><br>20% of the cost for each Medicare-covered radiation therapy service.<br><br>\$25 or 20% of the cost for each Medicare-covered X-ray visit.<br><br>(See page 16 for information on Diagnostic Tests, X-rays, and Lab Services.) |

❶ Each year, you pay a total of one \$124 deductible.

❷ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION II: Summary of Benefits****BENEFIT CATEGORY****Original Medicare****SecureHorizons Direct<sup>SM</sup> Plan 4****Preventive Services****22 Bone Mass Measurement**  
(for people with Medicare who are at risk)You pay 20% of Medicare-approved amounts.<sup>❶</sup>

There is no copayment for each Medicare-covered Bone Mass Measurement.

(See page 17 for information on Bone Mass Measurement.)

**23 Colorectal Screening Exams**  
(for people with Medicare age 50 and older)You pay 20% of Medicare-approved amounts.<sup>❶</sup>

You pay \$0 for each Medicare-covered Colorectal Screening exam.

An additional facility charge may be included in the cost for services.

(See page 17 for information on Colorectal Screening Exams.)

**24 Immunizations**  
(Flu vaccine, Hepatitis B vaccine — *for people with Medicare who are at risk*, Pneumonia vaccine)

There is no copayment for the Pneumonia and Flu vaccines.

You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine.<sup>❶</sup>

You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.

There is no copayment for the Pneumonia and Flu vaccines.

There is no copayment for the hepatitis B vaccine.

(See page 17 for information on Immunizations.)

**25 Mammograms (Annual Screening)**  
(for women with Medicare age 40 and older)You pay 20% of Medicare-approved amounts.<sup>❶</sup>

No referral necessary for Medicare-covered screening

There is no copayment for Medicare-covered Screening Mammograms.

(See page 17 for information on Mammograms (Annual Screenings).)

<sup>❶</sup> Each year, you pay a total of one \$124 deductible.<sup>❷</sup> If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.

**SECTION II: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>                                                               | <b>Original Medicare</b>                                                                                                                                                                       | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>26 Pap Smears and Pelvic Exams</b><br>(for women with Medicare)                    | There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. <sup>❶</sup><br><br>You pay 20% of Medicare-approved amounts for Pelvic Exams. <sup>❶</sup> | You pay:<br><br>\$0 for each Medicare-covered Pap Smear and Pelvic Exam<br><br>\$0 for each additional Pap Smear and pelvic Exam up to 1 Pap Smear(s) and Pelvic Exam(s) every year.<br><br>(See page 17 for information on Pap Smears and Pelvic Exams.) |
| <b>27 Prostate Cancer Screening Exams</b><br>(for men with Medicare age 50 and older) | There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. <sup>❶ ❷</sup>                                                 | There is no copayment for Medicare-covered Prostate Cancer Screening Exams.<br><br>(See page 17 for information on Prostate Cancer Screening Exams.)                                                                                                      |
| <b>28 Outpatient Prescription Drugs</b>                                               | You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.                                                                                  | You pay 100% for most prescription drugs.<br><br>This plan does not cover Medicare Part D prescription drugs.<br><br>(See page 17 for information on Outpatient Prescription Drugs.)                                                                      |

**Additional Benefits (what Original Medicare does not cover)**

|                           |                                               |                                               |
|---------------------------|-----------------------------------------------|-----------------------------------------------|
| <b>29 Dental Services</b> | In general, you pay 100% for dental services. | In general, you pay 100% for dental services. |
|---------------------------|-----------------------------------------------|-----------------------------------------------|

❶ Each year, you pay a total of one \$124 deductible.

❷ If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION II: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>    | <b>Original Medicare</b>                                                                                                                                                                                                                                                                                                                                                                                           | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>30 Hearing Services</b> | <p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams.<sup>①②</sup></p>                                                                                                                                                                                                                                                         | <p>In general, you pay 100% for routine hearing exams and hearing aids.</p> <p>You pay:<br/>\$10 for each Medicare-covered hearing exam (diagnostic hearing exams).</p>                                                                                                                                                                                                                                              |
| <b>31 Vision Services</b>  | <p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.<sup>①②</sup></p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings.<sup>②③</sup></p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.<sup>②④</sup></p> <p>You pay 100% for routine eye exams and glasses.</p> | <p>You pay 100% for non-Medicare-covered eye exams and glasses.</p> <p>You pay:<br/>\$30 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery).<br/>\$25 for each Medicare-covered eye exam (diagnosis and treatment of diseases and conditions of the eye).</p>                                                                                                      |
| <b>32 Physical Exams</b>   | <p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.<sup>①⑤</sup></p>                                                                     | <p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay \$0 for Medicare-covered services.</p> <p>You pay \$0 for each exam.</p> <p>You are covered up to 1 exam(s) every year.</p> |

<sup>①</sup> Each year, you pay a total of one \$124 deductible.

<sup>②</sup> If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION III: Summary of Benefits****BENEFIT CATEGORY****SecureHorizons Direct<sup>SM</sup> Plan 4****Premium and Other  
Important Information**

The annual Out-of-Pocket Maximum limit every year applies to all Covered Services you receive. You are **not** required to receive Covered Services through a contracted network of Providers.

**Doctor Choice**

You may obtain Covered Services from any Medicare Eligible Physician anywhere in the United States. Each time you go to the Physician's office for services, you must:

1. Show your SecureHorizons Direct<sup>SM</sup> Plan ID card.
2. Confirm that your Physician is Medicare eligible, which means that he/she is state licensed, has a Medicare billing number or is eligible to obtain one.
3. Determine whether your Physician accepts Medicare Assignment as full payment.
4. Understand whether or not services you are about to receive are covered benefits. If you are at all unsure, you should contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774, or for the hearing impaired, TTY 1-888-685-8480, 8 a.m. to 10 p.m. EST, Monday through Friday, for an Advance Coverage Decision.

A Physician is considered Deemed when the following conditions are met:

- 1) In advance of furnishing Covered Services, the Physician knows that a patient is enrolled in SecureHorizons Direct<sup>SM</sup>.
- 2) The Physician either possesses or has access to PLHIC's Terms and Conditions of payment and participation (which is available by calling the 800 number for providers on the back of your ID card).
- 3) The Physician agrees to submit the bill for Covered Services directly to PLHIC for payment.

It is important to note that the Physician has the right to decide whether or not he/she will agree to be a Deemed Physician each time he/she furnishes Covered Services to you.

If the Physician bills you directly for Covered Services, forward the claim to PLHIC for payment to your Physician for Covered Services, minus your cost-sharing amount.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION III: Summary of Benefits****BENEFIT CATEGORY****SecureHorizons Direct<sup>SM</sup> Plan 4****Doctor Choice (continued)****Physician Payment**

If the Physician informs you that he/she accepts Medicare Assignment and furnishes Covered Services to you, you are only required to pay the cost-sharing amount allowed by the SecureHorizons Direct<sup>SM</sup> Plan. PLHIC is responsible for the rest of the fee. The Physician who accepts Medicare Assignment must accept PLHIC's payment as payment in full and may not bill you for any amounts except for your share of costs outlined in the Schedule of Benefits and this Summary of Benefits.

If you select a Physician who **does not** accept Medicare Assignment, you may incur charges in excess of the Medicare Allowable Charges for Covered Services you receive. By law, Physicians who do not accept Medicare Assignment may charge you up to an additional 15% above the Medicare Allowable Charges. These are called "Part B Excess Charges." You will be responsible for paying these Part B Excess Charges. However, Part B Excess Charges count toward your annual Out-of-Pocket Maximum and PLHIC will pay any Part B Excess Charges you incur after the Out-of-Pocket Maximum has been reached.

If a Provider furnishes a service to a plan Enrollee that is **not covered** by SecureHorizons Direct<sup>SM</sup>, PLHIC is not required to pay for the service. The Enrollee is responsible for payment to the Provider.

**Inpatient Hospital Care**

You pay \$200 each day for days 1-4;  
You pay \$0 for days 5+

**Inpatient Mental Health Care**

You pay \$200 each day for days 1-4;  
You pay \$0 for days 5-190

**Skilled Nursing Facility**

You are covered up to 100 days each benefit period for a medically necessary, Medicare-covered stay in a skilled nursing facility. A benefit period begins the first day of a Medicare-covered skilled nursing care facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were not a patient of a SNF.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION III: Summary of Benefits****BENEFIT CATEGORY****SecureHorizons Direct<sup>SM</sup> Plan 4****Emergency Care**

You may receive Emergency Services anywhere in the world without any prior approval from PLHIC.

**Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the Enrollee's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

In case of a pregnant woman, an Emergency Medical Condition exists if the Enrollee is in active labor, meaning labor at a time at which either of the following would occur:

- there is inadequate time to effect safe transfer to another hospital prior to delivery; or
- a transfer may pose a threat to the health and safety of the Enrollee or of the unborn child.

**Emergency Services** – Covered Services that are:

- furnished by an emergency room Provider qualified to furnish Emergency Services, and
- needed to evaluate or stabilize an Emergency Medical Condition.

**Urgently Needed Care**

You may receive Urgently Needed Services anywhere in the world without any prior approval from PLHIC.

**Urgently Needed Services** – Covered Services that are:

- provided in an urgent care facility when your Physician is temporarily unavailable or inaccessible, or
- when such services are Medically Necessary and immediately required as a result of an unforeseen illness, injury or condition.

Covered Services provided by an emergency room Provider are considered Emergency Services, not Urgently Needed Services.

**Diagnostic Tests, X-rays, and Lab Services**

\$25 copayment for each Medicare-covered standard X-ray visit.

20% coinsurance for covered complex radiology services and imaging procedures. These procedures require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

**SECTION III: Summary of Benefits**

| <b>BENEFIT CATEGORY</b>                    | <b>SecureHorizons Direct<sup>SM</sup> Plan 4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Bone Mass Measurement</b>               | \$10 office visit copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Colorectal Screening Exams</b>          | \$10 primary care physician or \$20 specialist office visit or \$100 outpatient hospital copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Immunizations</b>                       | \$10 office visit copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Mammograms<br/>(Annual Screenings)</b>  | \$10 office visit copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Pap Smears and<br/>Pelvic Exams</b>     | \$10 office visit copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prostate Cancer<br/>Screening Exams</b> | \$10 office visit copay may apply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Outpatient<br/>Prescription Drugs</b>   | The outpatient prescription drugs listed in Section I are covered under Medicare Part B and included in your SecureHorizons Direct <sup>SM</sup> benefit plan. The Medicare Part D prescription drug benefit available January 1, 2006, is not part of your SecureHorizons Direct <sup>SM</sup> plan. To obtain Medicare Part D prescription drug benefits, you will have to select a Prescription Drug Plan and you will receive a separate bill for any premium due for the Medicare Part D benefit. The Medicare Part D premium will be in addition to your SecureHorizons Direct <sup>SM</sup> health plan premium, if applicable. |

**Section III: Summary Limitations and Exclusions**

All items and services, procedures, treatments, and supplies which are not Medically Necessary to treat an illness or injury and which do not meet Medicare program standards are not covered. Please refer to the document entitled *2006 SecureHorizons Direct<sup>SM</sup> Limitations and Exclusions* for the exact limitations and exclusions for the SecureHorizons Direct<sup>SM</sup> benefit plan. Please note that additional Limitations and Exclusions apply to all Covered Services as defined in the Limitations and Exclusions document and other plan documents.

*If you have any questions about this plan's benefits or costs, please contact SecureHorizons Direct<sup>SM</sup> at 1-866-579-8774 or (TTY 1-888-685-8480), 8 a.m. to 10 p.m. EST, Monday through Friday, for details.*

## Notes

## **Notes**

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SecureHorizons Direct<sup>SM</sup>  
P.O. Box 489  
Cypress, CA 90630

**Sales Information**

1-800-776-8876  
TTY/TDD 1-800-387-1074  
6 a.m. to 7 p.m. PST  
Monday through Friday  
8 a.m. to 12 p.m. PST  
Saturday

Visit our Web site at  
[www.securehorizons.com](http://www.securehorizons.com)

*Before you seek covered services, providers must be informed of your SecureHorizons Direct<sup>SM</sup> membership. Hospitals and most other non-physician providers must accept Medicare Assignment. However, if a non-participating physician, physical therapist, occupational therapist or durable medical equipment supplier does not accept Medicare Assignment, you may incur expenses not covered by SecureHorizons Direct<sup>SM</sup>. Please contact SecureHorizons Direct<sup>SM</sup> for details.*

*You must be entitled to Medicare Part A and enrolled in Medicare Part B. You must continue to pay the Medicare Part B premium and live in the SecureHorizons Direct<sup>SM</sup> covered service area. If you currently have End Stage Renal Disease (ESRD) and receive routine dialysis treatment to maintain life, you may not enroll in the SecureHorizons Direct<sup>SM</sup> unless you are currently a PacifiCare Commercial plan member.*

*SecureHorizons Direct<sup>SM</sup>, a Medicare Advantage Private Fee-For-Service Plan, is offered by PacifiCare Life and Health Insurance Company, which contracts with the federal government. Limitations, copayments and coinsurance will apply. Health plan premiums and plan benefits may vary by state and county.*

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SecureHorizons Direct<sup>SM</sup>  
from **PacifiCare**<sup>®</sup>  
A Private Fee for Service Health Plan

# **Exhibit “A”**

